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The JOURNAL

July 1975
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Indianapolis



OF THE INDIANA STATE
MEDICAL ASSOCIATION



ISMA ANNUAL MEETING • October 20-22, 1975 • French Lick

Both often



- Predominant psychoneurotic anxiety

- Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor

neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

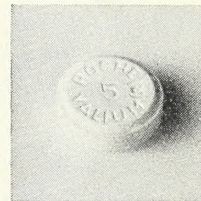
respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent

in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium[®] (diazepam) 2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

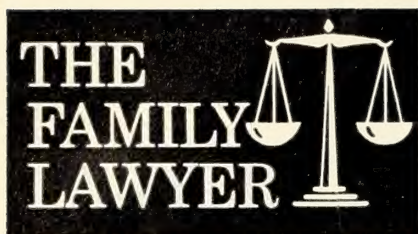
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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313376



"EVERYBODY DOES IT"

Pedestrian Jenks, bowled over by an automobile, decided to sue the motorist for damages. But in a court hearing, the motorist pointed out that Jenks had been crossing in the middle of the block.

"What of it?" countered Jenks. "Crossing in the middle of the block happens to be the customary thing at that particular location. As long as everybody does it, that can't be held against me."

However, the court ruled that

Jenks was indeed guilty of negligence—regardless of the custom. The judge said the mere fact that many people do something wrong does not make it right.

This is the law's usual attitude toward those who follow someone else's bad example. And it applies not only to those who suffer an injury but also to those who inflict an injury.

For example:

An eight-year-old boy threw a rock at a playmate, damaging his eye. In the litigation that followed, the defense attorney tried to excuse his young client by arguing that "healthy boys of his age have done (the same thing) from time immemorial."

But again the court ruled that rock-throwing, however common,

was still wrongful because of its inherent danger.

On the other hand, while custom does not excuse negligence, it may at least shed light on what negligence is. In another case, a hurrying shopper crashed into the plate glass door at a market, shattering the glass. She claimed damages later on the ground that the panel should have been thicker.

But experts testified that the glass was of standard thickness, the kind used almost universally in market doors. Dismissing the woman's claim, the court said the custom of the trade was persuasive evidence that the company had simply not done anything wrong.

A public service feature of the American Bar Association and the Indiana State Bar Association. Written by Will Bernard.
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SCIENTIFIC EXHIBIT APPLICATION FORM

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All articles must be typewritten, double-spaced with margins of one inch.

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Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 3266 N. Meridian St., Room 705, Indianapolis 46208. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

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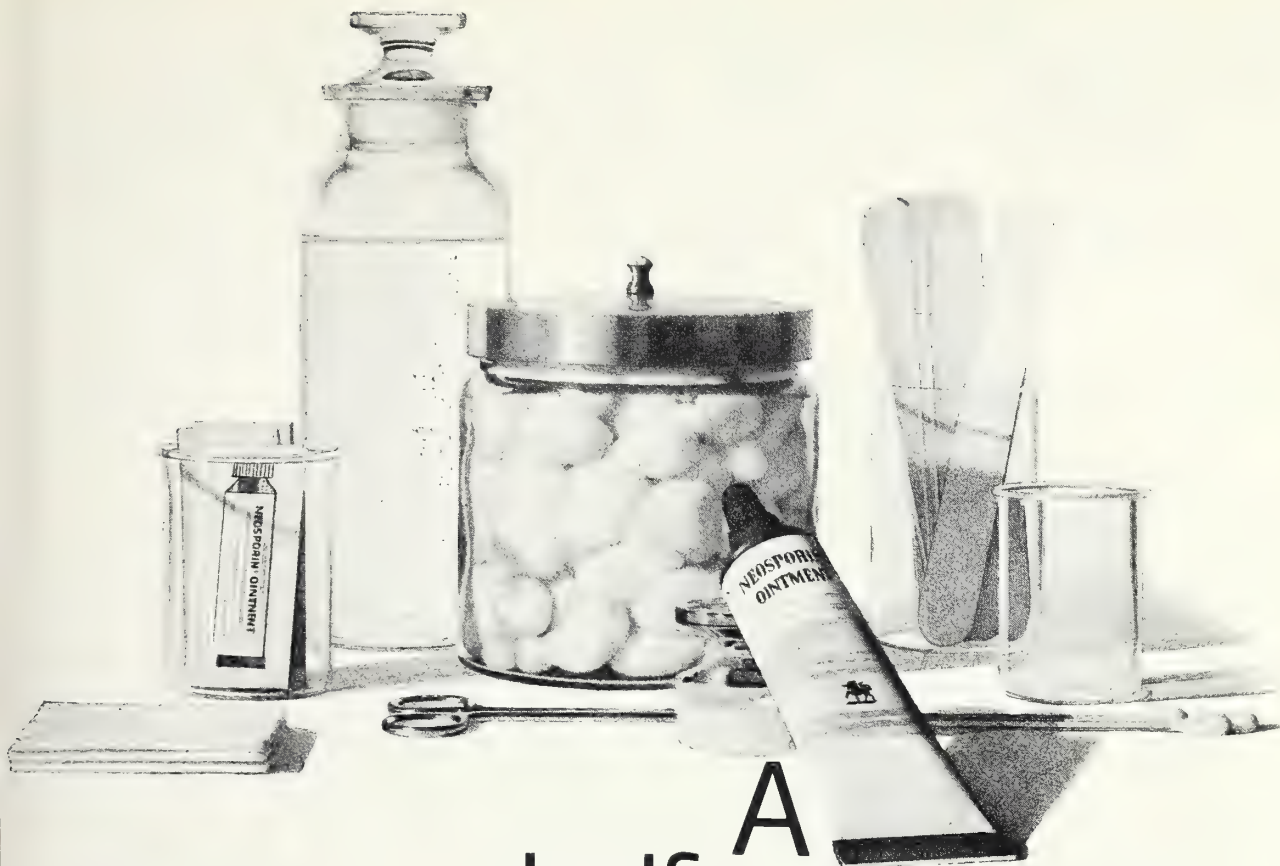
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CONTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have known hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where

absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

* WARNING

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium fre-

quently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy

patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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to help keep potassium levels up.



This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

THE AMERICAN MEDICAL ASSOCIATION HAS URGED all members of the House of Representatives to oppose two key provisions of a health manpower bill that would extend federal control over medical education.

The controversial sections of the bill that won easy passage in the House Interstate and Foreign Commerce Committee would:

- Establish federal control of the number and location of medical residencies.
- Require all medical students to repay the federal government for U.S. aid to the school.

In a letter dispatched to the 435 lawmakers in the House, the AMA stressed continued support for federal assistance to medical schools and students. However, the Association said "strong objection is raised" to "certain new concepts" that would impose restrictions on students and on residencies.

The health manpower bill won approval by the House Commerce Committee with the two disputed provisions by roughly a 2-1 margin. The bill authorizes \$1.7 billion for aid to medical, dental, nursing and other schools with a \$2,100 per student capitation subsidy by the federal government for medical students.

A House vote is expected about midsummer. The Senate has not yet considered the bill.

The AMA told House Members:

"These requirements—that the students, as a personal obligation, repay to the federal government those amounts which the government has given to the schools—are without precedent and are discriminatory against health professions' students. These conditions are not imposed on students in other fields, nor should they be. This amounts in effect to a forced loan required of all health professions' students under the bill. Once again, through the service requirements attached to the loan forgiveness features, the low income or disadvantaged student would carry a disproportionate burden. "The best way to attract individuals to shortage areas," according to the AMA, "is through mechanisms which allow the individual voluntarily to commit himself to service in a needy area. As to government programs, this could be done through such programs as

the National Health Service Corps, scholarships for service in shortage areas, loan forgiveness or other incentive programs.

"It should not be done through a program where all students are under the burden of insuring that the federal assistance given to the school is repaid by the student," the AMA said.

The proposed control of medical residency training programs amounts to "the rationing of medical education . . . and poses many threats to our quality education system," according to the AMA.

The bill would establish two agencies: one would be responsible for accrediting medical residency training programs in the U.S.; the other for establishing the number of positions which could be filled in each residency program.

The aggregate limit on the number of positions which could be available in years 1978, 1979, and 1980 would be an amount equal to 155%, 140% and 125%, respectively, of the estimated number of graduates from accredited U.S. schools of medicine in the year preceding.

Priority for designation would be the Liaison Committee for Graduate Medical Education of the Coordinating Council on Medical Education (CCME) as the accrediting agency, and the CCME as the agency to establish the number of residency positions. The latter agency would determine the geographic distribution of residency training positions, the number of positions in each program, and an allocation of positions among the various specialties. In the absence of designation of the named agencies, the activities would be undertaken by another organization designated by the HEW Secretary.

Included with the AMA letter to the congressmen was a copy of an article in the *Journal of the Tennessee Medical Association* by Tom Nesbitt, M.D., speaker of the AMA House of Delegates and chairman of the CCME. Dr. Nesbitt wrote that a question posed by the legislation is "of the private voluntary sector remaining voluntary, as opposed to its becoming an arm of the federal government, subject to its bureaucracy and its political influences and controls."

But the fight of the AMA and other medical

Continued on page 636

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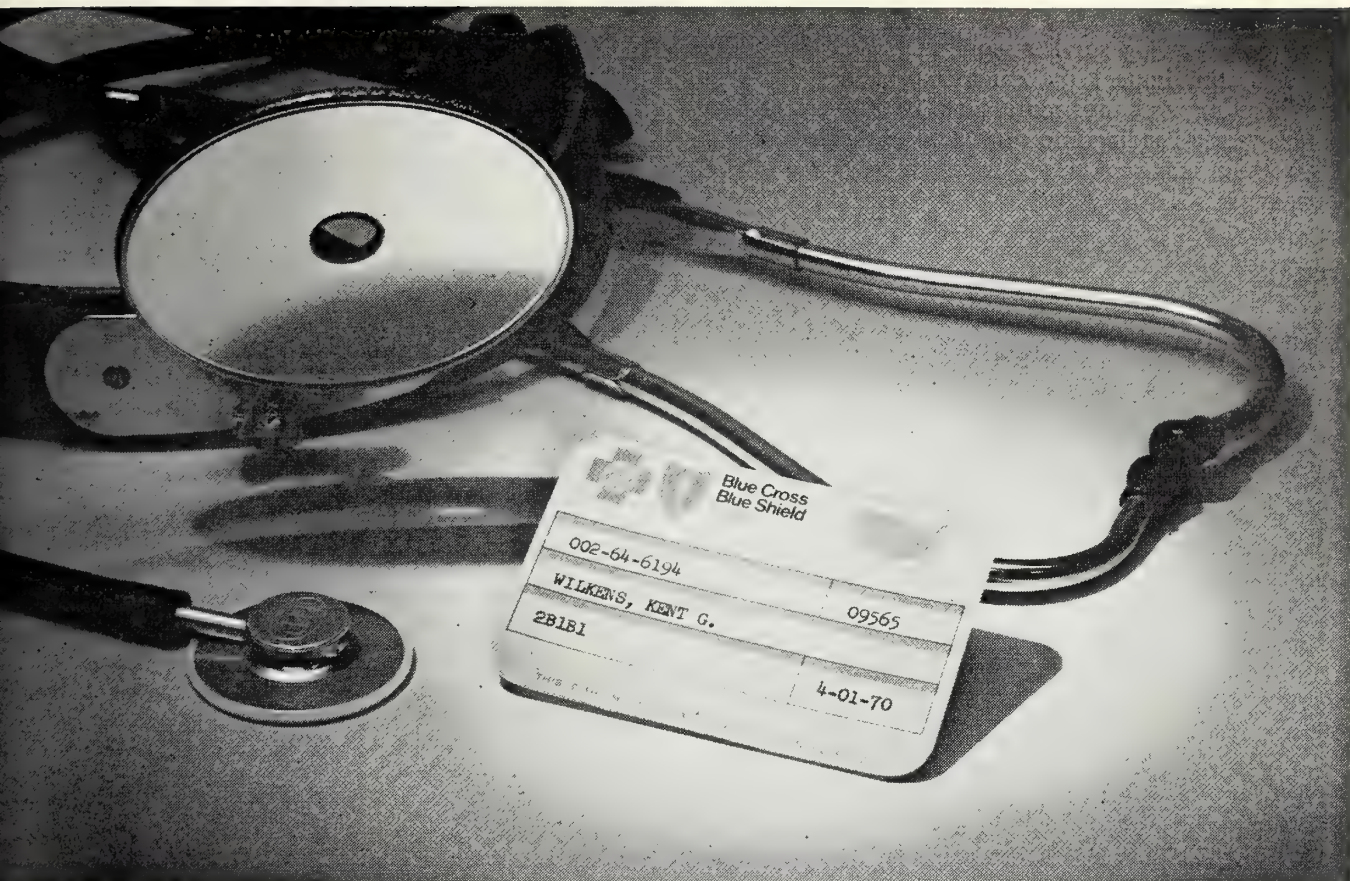
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organizations, including the Association of American Medical Colleges, to strike or limit the two controversial sections of the bill appears to be an uphill battle.

If the sweeping service requirement of the bill is retained, the impact on American medical practice would be marked with more than 10,000 young physicians yearly heading into rural areas, inner-city slums, and other shortage areas. Furthermore, the federal government—military, public health service and Veterans Administration—would have recruiting worries erased.

AROUSSED BY GROWING COMPLAINTS besides those of the AMA that government is superseding Congressional intent in issuing control regulations in the Medicare program, the House Ways and Means Committee has slated an unusual one-day session to "examine these policies."

The so-called "public oversight" session will deal with the controversial Utilization Review regulations under court challenge by the AMA (the first round won by the AMA May 27, 1975), the proposed rules governing Medicare reasonable charges and economic indices, reduction of inpatient payment for hospital routine service costs from the 90th percentile to the 80th percentile, and elimination of the special nursing differential for reimbursement to hospitals and skilled nursing facilities.

"Serious and widespread concerns have been raised about the policies in these regulations, including the question whether the special characteristics of small rural hospitals are adequately taken into account," said Subcommittee Chairman Dan Rostenkowski (D-Ill.). "The Subcommittee intends to examine these policies and their implementation in the light of Congressional intent relative to the conduct of the Medicare program."

The HEW Department's plan to tie physicians' Medicaid reimbursement to a national economic index has been assailed by the AMA as "inequitable and unfair." The "invidiousness" of imposing economic controls on one sector of the economy "is intensified when consideration is given to the fact that the controls and limits on the government financial contribution towards payment of the medical care of a Medicare beneficiary set arbitrary limits on prevailing charges, and thus shift an increasing burden onto the Medicare beneficiary," said the AMA.

In a statement, AMA Executive Vice President James H. Sammons, M.D., urged that the regs be withdrawn. Dr. Sammons noted that the two-year time lag already involved in the recognition of physicians' fees "is in itself unique and has operated in such a way that Medicare fee recognition has long lagged behind current trends in physicians' fees."

There is no justification in either the law or its

legislative history for the imposition of "a national economic index," said Dr. Sammons. The statement in the proposed regs that increases are to be 'fair to all concerned and follow, rather than lead, any inflationary trends' is contradictory and "when considered in the context of the history of restrictions and limitations placed upon Medicare fees, is an affront to the physicians who have cooperated through a long period during which there has been imposition of arbitrary freezes and targeted economic controls," the AMA official said.

Also attacked by the AMA was the lower reimbursement limit for hospital Medicare costs, to 80 percent from the present 90 percent. "The imposition of arbitrary ceilings on hospital revenues affects the quality of service available to Medicare patients" and may force some hospitals to treat Medicare patients at a loss, Dr. Sammons said.

"Fixing a ceiling limitation on reimbursement by bed size and location for all hospitals does not establish the existence—or lack—of efficiency," said the AMA. "This simplistic approach provides no assurance that inefficiency will be corrected or that efficient operations will be rewarded. The proposed system simply applies pressure to reduce per diem costs to a set dollar amount without regard to how such reductions may be attained, and appears to be predicated upon ease of administration rather than the elimination of unnecessary costs flowing from inefficient operation."

STATE LEGISLATORS FROM ACROSS THE NATION meeting in Washington on malpractice were told that "massive federal intervention" would cause "irreparable harm," probably increase overall costs, lead to federal strings attached, and simply attempt to "paper the problem over with dollars."

HEW Assistant Secretary of Health, Theodore Cooper, M.D., told the National Conference of State Legislatures that he is confident the legislators "are not about to relegate to the U.S. Government the states' responsibility over insurance and medical practice."

The meeting was arranged by the National Conference and the newly formed Health Policy Center of Georgetown University to discuss malpractice insurance "as the perfect example of the need for federal-state coordination," in the words of Don Herzberg, Dean of Georgetown's Graduate School.

The sponsoring organizations had hoped that some form of consensus and call for action might emerge from the three-day session, but the state lawmakers could only agree at this time that the situation was serious and that the remedies in sight appeared to be short-term ones. Several spoke of the difficulties in persuading consumer advocates in their state legislatures that a crisis exists that affects patients as well as physicians or that legislative remedies were not aimed

at bailing out hard-pressed insurance companies.

Dr. Cooper urged the states to enact new laws covering professional liability. He said there is need for public education to the fact that there are unavoidable limitations to medical care, that not all injuries are, in fact, malpractice, that people are not entitled to compensation simply because they have suffered.

LEGISLATION TO REQUIRE ALL CLINICAL LABORATORIES to meet specified federal standards is slated for a close Congressional look this year. Physicians' private office labs could be covered under draft legislation if work is done for more than one physician.

The measure backed by Sens. Jacob Javits (R-N.Y.) and Edward Kennedy (D-Mass.) gives some discretion to HEW on the sweep of the standards coverage. However, all labs, including those now considered strictly intra-state, would have to meet federal standards.

The program would be administered at the state level by a single state agency which could issue licenses in the name of the federal government.

The Center for Disease Control, U.S. Public Health Service, would provide assistance and check on progress of state efforts, but a new HEW Office of Clinical Laboratories would be the chief supervisor.

The state programs could rely on professional accrediting and testing programs, but spot-checking and testing by the federal agency is authorized.

The licensing standards cover quality control, record-keeping, personnel, and participation in proficiency testing.

Many features of the legislation are certain to arouse controversy.

THE AMERICAN SOCIETY OF INTERNAL MEDICINE (ASIM) has agreed to participate in the Federated Council for Internal Medicine—provided that policy decisions by the Council are made only by unanimous vote of the four member groups.

The Council would attempt to coordinate policies and actions of the four organizations in the internal medicine field—ASIM, the Association of Professors of Medicine, the American Board of Internal Medicine and the American College of Physicians.

The ASIM agreement to participate came at its annual meeting in Washington.

According to a report by the ASIM's Board of Trustees, the Council has the potential to:

- Identify internal medicine as a unified community of physicians capable of collective action.
- Improve the quality of debate and decisions on major public issues of concern to internal medi-

cine, and provide a medium to establish a consensus within the specialty in advance of public pronouncements.

ASIM also voted to support a national health insurance measure that would cover the costs of catastrophic illness. "This insurance should be supplied by private carriers to the greatest extent possible," the resolution declared.

Comprehensive coverage for all medical care needs would be inflationary and add unnecessary stress to an already overburdened economy, according to the resolution.

E. Harvey Estes, M.D., Director of Duke University's Department of Community Health Sciences, was named "Distinguished Internist of the Year" by ASIM.

William R. Felts, M.D., an internist and rheumatologist practicing in Washington, D.C., was elected ASIM president-elect. Dr. Felts is director of the Division of Rheumatology at George Washington University Medical School. He has been one of the Society's trustees since 1969 and served as chairman of its Liaison Council. He will serve as president following the one-year term of Ralph F. Reinfrank, M.D., who assumed office during the meeting. ◀



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Utilization of the Physician's Assistant in Indiana

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Introduction

In today's society there exists an ever-growing concern over the serious deficit in primary physician services. With the high cost of health care consistently rising, increased demands are being made for better health care practices. The problems now facing the medical profession emphasize the lack of supply, distribution, organization, utilization and financing of physician services.⁴

The problems of health care are not mutually exclusive of one another; rather, they are interrelated and dependent. The problems have manifested themselves in overburdened physicians, rapidly rising medical costs, lack of appropriate use of equipment and facilities, lack of any medical care in many rural areas, maldistribution of physicians in urban areas, and delays in seeking medical care by the population.

Indiana is no different than most agricultural-industrial states with respect of these health care delivery problems. With only one state medical school and a few satellite programs which feed students into the state medical school, not enough physicians are being produced to meet the needs of the Indiana population. Indiana also suffers from maldistribution, over-specialization, lack of comprehensive preventive medicine, and the many other factors which plague most states.

The trend toward the transfer of medical tasks to non-physicians has been one way in which to increase the productivity in the health care system. The idea of the physician's

assistant was conceived in the 1960s to meet this goal.^{9,10} The delegation of tasks from physicians to non-physicians has been slow and many factors are involved.⁶

This study was undertaken in order to determine the impressions of practicing, licensed physicians in Indiana concerning the utilization, roles and acceptance of the physician's assistant concept. The study was completed in August 1974.

Method

The population for this study consisted of a 10% random sample of physicians practicing in Indiana, using the appropriate professional directory. Since physicians are not li-

TABLE I
A BREAKDOWN OF THE INDIANA PHYSICIAN SAMPLE BY MEDICAL SPECIALTY

SPECIALTY	ABSOLUTE FREQUENCY	RELATIVE FREQUENCY (%)	ADJUSTED RELATIVE* FREQUENCY (%)
General Medicine	81	36.0	38.8
Internal Medicine	17	7.6	8.1
General Surgery	23	10.2	11.0
Obstetrics & Gynecology	8	3.6	3.8
Pediatrics	9	4.0	4.3
Psychiatry	7	3.1	3.3
Public Health	2	0.9	1.0
Other	62	27.6	29.7

Valid observations = 209
Missing observations = 16

* Adjusted for missing observations

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censed by medical specialty and do not always practice in a strict specialty setting, no attempt was made for a stratified random sample.

The questionnaire utilized was constructed and items selected on the basis of job descriptions, tasks, and functions presented or proposed, in some form, in clinical settings, or in physician's assistant training programs, and to physician's assistants throughout the country. A questionnaire with an explanatory letter and return envelope was mailed to each of the physicians.

Results

Four hundred fifty-one questionnaires were mailed to physicians. Of these, 225 were returned, representing a 51.3% questionnaire return. Tables I and II give a breakdown of the physician sample by medical specialty and age. Under the category of "other" in these tables, include the medical specialties: thoracic surgery, anesthesiology, radiology and pathology. Of the physicians surveyed, 38.8% practiced general medicine and 11.0% general surgery. It was also observed that 32.0% of the physicians were 41-50 years of age and 28.4% were between 51-60 years old. Approximately 34% have practiced medicine for more than 30 years and 53.9% of the physicians sampled practiced alone. More than 42% of the physicians practiced in urban areas with greater than 100,000 population and only 8.1% of the physicians were practicing in areas of 5,000 or less population. Furthermore, 90.6% of the physicians were

located within 10 miles of a hospital. No physician was located more than 30 miles from a hospital.

Analysis of Data

An analysis of the data revealed that physicians as a group agree with the philosophy of the physician's assistant concept. The majority of Indiana physicians felt that the physician's assistant should be trained through approved academic programs which were under the direction of recognized medical schools. In conjunction with this, the physicians (79.9%) felt that standardization in terms of quality and program content was desirable. Many thought they would rather train the physician's assistant themselves for the specific needs of their own practice. Some Indiana physicians felt that the training programs could be offered through local hospital training schools and Family Practice Residency Training Programs, as well as through medical schools.

The next area of analysis dealt with legal responsibility. Only 25% of the Indiana physicians responding believed that the physician's assistant should be legally responsible for his performance.

Almost 66% of the Indiana physicians said that the physician's assistant should be permitted to write certain prescriptions. Also, 41% said that the physician's assistant should be able to write patient orders in the hospital.

The majority of Indiana physicians (53.8%) felt that the physician's assistant should be able to detect abnormal signs and symptoms

and make preliminary diagnoses based on the results of such examinations and report these on patients' permanent records or charts. Nearly 52% of the Indiana physicians said that their patients would accept the physician's assistant to take care of them when they were sick.

Approximately 75% felt that the role of the physician's assistant overlaps that of the registered nurse.

Most of the sample did not feel that the widespread use of the physician's assistant would reduce the present quality of health care. Related to this, almost 70% of the Indiana physician sample felt that present health care delivery services need to be restructured.

The most quoted salary range for the physician's assistant was in the eight to ten thousand dollar range.

Most Indiana physicians stated that if they were to employ a physician's assistant, they would devote more time to existing patients.

Approximately 16% of the Indiana physicians, at present, employ a physician's assistant and nearly 64% said they would consider employing a physician's assistant in the future.

Discussion

At present, there is little standardization to the role of the physician's assistant. This situation is certainly realized by the practicing physician. Because the role of the physician's assistant is vague, the relationships between physician and physician's assistant will vary. As the physician gains trust and professional respect for the physician's assistant, the turnover of job functions from physician to assistant will increase.

Only 25% of the Indiana physicians responding felt that the physician's assistant should be legally responsible for his performance. In most states, physicians have the legal right to delegate job functions or tasks to persons qualified to perform the duty. It is expected that the physician be familiar with the qualifications of the health person to whom he is transferring the function. The right of all physi-

TABLE II
A BREAKDOWN OF THE INDIANA PHYSICIAN
SAMPLE BY AGE

AGE (YEARS)	ABSOLUTE FREQUENCY	RELATIVE FREQUENCY (%)	ADJUSTED RELATIVE* FREQUENCY (%)
21-30	6	2.7	2.7
31-40	40	17.8	17.8
41-50	72	32.0	32.0
51-60	64	28.4	28.4
61-70	36	16.0	16.0
Over 70	7	3.1	3.1

Valid observations = 225

Missing observations = 0

*Adjusted for missing observations

cian's assistants to assume their job descriptions comes from the physician's privilege to delegate jobs. With the increasing number of physician's assistants being trained, the subject of sole legal liability is one gaining a great deal of attention.

One problem with legal liability is that a complete description of job functions must exist so that the courts can judge whether one is medically and legally at fault. Currently, no court cases exist upon which we can base statements of limitations. At present, the only way such a description of job function can exist is through licensure of some sort. The concept of the physician's assistant is relatively new and the role of the physician's assistant is somewhat vague. Such a situation gives the physician and assistant a great deal of flexibility in what functions the physician's assistant can perform. At this time sole legal liability and licensure may confine the physician's assistant to a lower level than is desired.

One area of examination was concerned with how physicians perceive the patient-oriented functions of the physician's assistant. Almost 66% of the Indiana physicians said that the physician's assistant should be permitted to write certain prescriptions. Also, 41% said that the physician's assistant should be able to write patient orders in the hospital. There frequently tends to be a resistance to the transfer of job functions when the transfer is seen as a surrender rather than a delegation. This has certainly been true of nursing professions in recent years; however, some physicians have knowingly and willingly given the right to prescribe certain medications and write patient orders to their physician's assistant. The response to this study seems to indicate that a significant portion of physicians see this as a delegation of authority and not one of surrender.

Also related to the above is the fact that the majority of Indiana physicians felt the physician's assistant should be able to detect abnormal signs and symptoms and make

preliminary diagnoses based on the results of such examinations and report these on patients' permanent records or charts. This indicates that most physicians see an expanded and integral role for the physician's assistant in providing primary health care. Furthermore, nearly 52% of the Indiana physicians said that their patients would accept the physician's assistant to take care of them when they were sick.

Approximately 75% of the Indiana physicians sampled felt that the role of the physician's assistant overlaps that of the registered nurse. This is interesting in view of the results of this study in which the majority of physicians feel that the physician's assistant concept is a good one. Replication of services and job functions is a major problem in modern health care. The lack of standardized job descriptions and evidence of need for services is responsible, in part, for the problem. It would seem somewhat inconsistent that most physicians would be in favor of a concept which they feel overlaps a pre-existing profession. This demonstrates a basic misinterpretation of the total physician's assistant concept.

Most physicians did not feel that the widescale use of physician's assistants would reduce the present quality of health care. Related to this area, almost 70% of the Indiana physician sample felt that health care delivery services need to be restructured. This indicates a realization by Indiana physicians that, in part, much of the activity which dominates a physician's schedule is activity which can easily be performed by someone other than a physician.

Conclusions

On the basis of the data collected from this survey of physicians concerning the utilization of the physician's assistant in Indiana, the following conclusions are made:

1. The majority of physicians feel that the physician's assistant should be trained in approved programs.

2. Only 25% of the physicians think that the physician's assistant should be legally responsible for his performance.
3. The majority of physicians feel that the physician's assistant should be permitted to write certain prescriptions.
4. The majority of physicians feel that the physician's assistant would be accepted by their patients.
5. Nearly three fourths of the physicians believe that the role of the physician's assistant overlaps that of the registered nurse.
6. Nearly 70% of the physicians felt that health care delivery needs to be restructured in order to better meet patient needs.
7. Most physicians would devote more time to existing patients if they were to employ a physician's assistant.
8. The vast majority of physicians feel that the physician's assistant is a valuable member of the health care team and will improve the quality of patient care.

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A Survey of Physician's Assistants in Indiana*

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DAN P. FOX, P.A.
Fort Wayne

THE Physician's Assistant concept has undergone many changes since its initiation in 1965 by Dr. Eugene Stead at Duke University. Some of these changes are the development of a national accreditation process to standardize the educational preparation, development of a national certifying

examination to evaluate each graduate and passage of enabling legislation by 36 states regulating the functions of the P.A. (see Table 1).

Following passage of the Comprehensive Health Manpower Training Act of 1971, which provided federal support for Physician's Assistant Training Programs, the American Medical Association developed and adopted the "Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician." The "Essentials" provide guidelines for use in developing P.A. Programs while maintaining flexibility by recognizing

different approaches to achieving educational objectives. More specifically, the "Essentials" are applicable to both the traditional P.A. Program and the MEDEX concept, which relies heavily upon supervised practical experience in a physician's office as the educational base.

The U.S. Office of Education has granted authority to the AMA to accredit those educational programs that the AMA determines meet the "Essentials" through a process of submission of formal documentation and site visitation. Since this process was implemented in August 1972,

*Introduction and summary of a full report to be published elsewhere under this title.

Ms. Wampler is the program evaluator and Mr. Fox is the assistant director of the Indiana University School of Medicine's Physician's Assistant Program. He is president of the Indiana Academy of Physician's Assistants.

TABLE I
STATES WITH A PA PROGRAM AND/OR PA LEGISLATION*

STATE	PA PROGRAM**	PA LEGISLATION	STATE	PA PROGRAM**	PA LEGISLATION
Alabama	X	X	Montana	—	X
Alaska	—	X	Nebraska	X	X
Arizona	X	X	Nevada	—	X
Arkansas	—	X	New Hampshire	X	X
California	X	X	New Jersey	—	X
Colorado	X	X	New Mexico	X	X
Connecticut	X	X	New York	X	X
Delaware	—	X	North Carolina	X	X
Florida	X	X	North Dakota	X	—
Georgia	X	X	Ohio	X	—
Hawaii	X	X	Oklahoma	X	X
Idaho	—	X	Oregon	—	X
Illinois	—	—	Pennsylvania	X	—
Indiana	X	—	Rhode Island	—	—
Iowa	X	X	South Carolina	X	—
Kansas	X	X	South Dakota	—	X
Kentucky	—	—	Tennessee	—	—
Louisiana	—	—	Texas	X	—
Maine	—	X	Utah	X	X
Maryland	X	X	Vermont	—	X
Massachusetts	X	X	Virginia	—	X
Michigan	X	X	Washington	X	X
Minnesota	—	—	West Virginia	X	X
Mississippi	X	—	Wisconsin	X	X
Missouri	X	—	Wyoming	—	X
			31 states		36 states

*Data taken from "National Physician's Assistant Program Profile, 1975-1976," published by the Association of Physician's Assistant Programs, 1974.

**There may be more than one program in each state.

approval status has been granted to 49 programs.

With the accreditation process under way, the P.A. profession recognized the need for assuring that all graduates were competent in the patient care areas outlined by the AMA. Contact was made with the National Board of Medical Examiners and in December 1973 the first National Certifying Examination was administered. The second administration took place in December 1974. It is felt that the National Certifying Examination can be used as a tool for approving an individual to function as a P.A., thus eliminating the need for each state to develop a mechanism for examining each P.A.

In August 1972, following several months of study, the Indiana University School of Medicine initiated a P.A. program and received funding from the federal government. The program is sponsored by the Department of Community Health Sciences and the Fort Wayne Center for Medical Education. It is located at the Fort Wayne Campus of Indiana/Purdue University and has received full accreditation from the AMA. In August 1974 the first class of 11 students was graduated from the Indiana University Program. Of the 11 graduates, 9 are in Indiana, one is in Maine, and one in California.

A part of the P.A.'s professional growth is the need for continued medical education. To fulfill this need, the graduate P.A.s in Indiana formed the Indiana Academy of Physician's Assistants (IAPA). This organization was incorporated on Nov. 4, 1974, with three ob-

jectives: (1) to render loyal and honest service to the medical profession and the public; (2) to offer continuing medical education programs for the P.A. in Indiana; and (3) to promote the P.A. concept through education of professional and lay people.

Any P.A. who is a graduate of an AMA approved program is eligible for membership. The Academy currently represents all the practicing P.A.s in Indiana and is composed of graduates of P.A. programs at Indiana University (9), Cleveland Clinic Educational Foundation (7), MEDEX Northwest at the University of Washington (2), Mercy College of Detroit (1), Alderson-Broadus College (1), and U.S. Public Health Service at Staten Island (1).

The IAPA has sponsored the first continuing medical education course for P.A.s in Indiana, developed a Code of Professional Practice for the P.A. in Indiana and published an informational booklet explaining the P.A.'s role in the delivery of health care. In addition, a survey was conducted by the IAPA in cooperation with the Indiana University Physician's Assistant Program. It represents information from 100% of the practicing P.A.s in Indiana.

Summary of the Survey

A questionnaire survey of all 20 graduates of AMA-approved Physician's Assistant Programs in practice in Indiana as P.A.s was completed in December 1974. All but four of the P.A.s had graduated in 1974 and have, therefore, been in practice less than a year. For this reason, the results of this survey should be considered preliminary.

The 20 P.A.s are in practice throughout the state, with the majority located in cities of less than 75,000 population. All 20 are supervised by licensed physicians. Fifteen are employed by private practices and five by institutions (hospitals and industry). Thirteen work in private practice settings with some also making hospital and nursing home rounds. Of the others, six work only in institutional settings such as a hospital emergency room or an industrial clinic, while one works both in a private practice and a hospital emergency room.

Most work between 40 and 50 hours a week, with 12 making some calls. All but four are covered by malpractice insurance. The average annual salary is around \$12,000.

There is a great deal of variation in the way in which these P.A.s fit into the practice in terms of who decides which patients the P.A. sees, whether or not the P.A. has his or her own patient caseload, situations where the physician always sees the patient, and situations where the P.A. must consult the physician. In most cases the P.A. sees all types of patients cared for in the practice; that is, there is little division of labor by type of patient, with either the P.A. or M.D., or both, seeing all types of patients.

Most of the P.A.'s time is spent in seeing patients. Very few are involved in clerical activities, laboratory work or extra-practice professional duties. Physician supervision varies depending on activity, type of patient and setting. All of the P.A.s work closely with physicians, with the physician always (or, for two P.A.s, usually) available for consultation. ◀

About Our Cover

An interesting and historically significant Southern Indiana structure graces our cover—Indiana's first Statehouse. Built at Corydon in 1814 as the Harrison County Courthouse, it also housed the territorial offices until Indiana attained statehood in 1916 and, after that, the offices of state officials. When the new Statehouse was built in 1824 the equipment was moved to Indianapolis in four large wagons. The building was restored in 1929.

The Private, Fee-for-Service, Community Health Center

J. FRANKLIN SWAIM, M.D.
Rockville

WITH the lamentable exodus of the revered "country doctor" from the Hoosier hinterlands, a vacuum of medical services has been created. There are countless numbers of towns throughout Indiana that are vehement in their attack upon organized medicine because they have no medical facilities in their communities. (The best publicized example was the late Mr. Philip Willkie's recent attempt to change the licensing procedure of the state Board of Medical Examiners and to import foreign doctors into his area of Indiana). People in the rural communities often have to travel 40 to 60 miles round trip to see the doctor of their choice in order to receive even the simplest and most basic medical care. It is my contention that this vacuum is going to be filled by some type of medical service, either by government medicine or private medicine. We private practitioners must either innovate change or we are going to be the victim of change.

Three Concepts Developing

Having attended the 25th and 26th National Rural Health conferences, I perceive three interrelated concepts that are developing across the nation which will allow the primary care physician to extend his medical care capabilities. These innovative approaches are as follows: (1) The Health Team Concept, (2) The Physician's Assistant, and (3) The Neighborhood or Community Health Center. The consensus of the conferences was that the primary care physician is going to have to accept a new role: that of heading up a health care team. The team will consist of allied health personnel with various levels of training, preferably and probably of ne-

cessity, recruited from the local area to be served. Each area will need to develop its own plan, incorporating those approaches most appropriate to its particular needs. Some areas will have no physician in residence and will have a community health center staffed by a physician's assistant who will, of necessity, be able to contact his physician employer at all times while in the office and before instigating any medical procedure or treatment. This physician's assistant will be an extension of, and not a substitute for the physician.

The concept of the community health center and physician's assistant is being implemented in many locations from Maine to California. Even the Mayo Clinic is experimenting with one.

The frightening thing to me, as a private practitioner, is the enthusiasm with which the federal government is entering the field. Some years ago the National Health Service Corps predicted they would have 60 health care teams working in different areas by July 1972. Private medicine is going to lose the battle for the right to provide medical care by default; we're not even a contender in supplying health care to many parts of the United States.

Most physicians prefer to remain in their plush offices in the major metropolises and let the patient travel great distances to see him. Furthermore, some will not accept new patients. Little do these physicians realize the personal and professional rewards that would accrue to them and their patients if they would utilize physician's assistants and delegate some of their work to the P.A.

In my 10 years of practice I have

watched with interest the developing concept of physician's assistants and satellite health facilities staffed by physician's assistants. I saw it utilized effectively while serving in the Air Force, both stateside and in Vietnam in 1966 and 1967. Finally, in August 1971, I saw an opportunity to develop a private, fee-for-service, community health center in a neighboring community, Kingman, Ind., which lost its last physician after having one for the past several decades. I approached the local businessmen and outlined how I thought a community health center would operate. They were impressed enough to buy the medical building and give me a lease-purchase agreement on it. I knew an R.N. in the area who was interested in working in such a facility.

Second Office Opened

I started going there one night a week initially. After two months, I determined that it would pay for a full time R.N., so I employed one and gave her two months of paid training at my Rockville office. In those two months, I taught her all I could about taking a medical history and doing a physical exam; the lab technician taught her how to do a blood sugar, a urinalysis and a hemoglobin; the bookkeeper taught her how to keep the books; and the R.N. in my office taught her about the medicines and drugs that I use. She started work in November 1971, and our operation is still going.

It has operated in the black every month, and the expense ratio compares favorably with my main office at Rockville. I still go there one night each week to see patients, and the patient load when I am there varies from 12 to 22.

During the week, when I am not at the Kingman office, every new undiagnosed patient that comes in is examined by the nurse, and she calls me to get a treatment order. If I have any question, they are sent on to my office in Rockville. She is allowed to do a few things without calling me, such as giving routine immunizations, refilling medication that I have prescribed and which I say on the patient's clinical record can be refilled.

At no time, however, does she practice medicine. This is a criminal act in Indiana. I understand it, and I make sure she understands it. Everything she does is on my verbal or written order. If malpractice is committed, then I have no recourse. However, if other health care delivery systems can utilize the physician's assistant in a remote, satellite office, then I think I can too, and I think a lot of other private physicians could.

The one thing that really makes the Kingman office a success is my going there one night a week. It would be a marginal operation otherwise. The nurse pays her own way, but she doesn't really generate much extra income. I do not think that any health planner need to worry about a physician sitting back and raking in the money from someone else's work. From my experience, it will only be a success if the physician goes to the remote facility on a regular basis, even though it is only once a week. It requires a lot of long hours and frustrating work, and the compensation on an hourly basis isn't all that good, but I would rather do this than spend my time on a golf course, and I can still make more per hour than doing anything else.

I have also had the gratification of seeing the town (ca. 500 population) continue to grow since I have been there, which may or may not have had anything to do with it. The old town newspaper was purchased by a new publisher (from Rockville) and rejuvenated and expanded. A new building was erected

to house it. A new tavern has been built (I didn't contribute too much toward this) and a small manufacturing facility moved to town about six months ago. It manufactures gloves and has been so successful that it is planning to build a new plant. I think organized medicine needs to think of the economic viability of these smaller communities throughout Indiana and the nation, and not just the medical needs in and of themselves. If they are economically viable and able to sustain the population and even grow some, then we are letting them down if we don't support them with some type of medical service, for this is indisputably important for any town's viability.

As organized at Kingman, we are providing less expensive medical care. The nurse charges two dollars less than I when she sees a patient and calls me. Fortunately, Medicaid has seen fit to reimburse us for this fee, so we can provide care for this segment of the population. It is interesting to note the difference across the United States regarding this point. Some physician's assistants charge the same as other physicians; the community health center operated by the Mayo Clinic charges more than the physicians in the area, and it is still operating successfully. I don't know how Medicaid programs in other states view the satellite facility operated by a physician's assistant, but I think it offers a great opportunity for them to save some taxpayers' money if the remote facility is set up with the correct fee structure. At Kingman, everyone is charged the same, whether private pay or Medicaid.

Continuity of Care Offered

The nurse is in the office six days a week, so I think there is good continuity of care. If she can contact me after hours, she will make a house call, if necessary. She is compensated for this on a percentage basis. If patients get sick after hours, and we can't be contacted, they are instructed to go to one of the hospitals where there is a doctor in the emergency room at all hours—such as Union Hospital

in Terre Haute or the Danville, Ill., hospitals.

In June 1972, I established a second satellite facility at Clinton, Ind., about 15 miles southwest of Rockville. The hospital that serves this area is located in Clinton, so I am there every day. By rearranging my Rockville schedule, I could work in an extra hour or two in Clinton every day.

The opportunity arose when one of the family physicians left his private practice to go to work full time in an emergency room facility at Union Hospital in Terre Haute. He left a fully equipped office across the street from the Clinton hospital with a very well trained and experienced office nurse. I purchased his office and employed his nurse.

She has an extensive background which makes her an ideal physician's assistant. She trained as a lab technician in the service shortly after graduating from high school. Prior to this she had worked in a bank and knew bookkeeping and accounting. She worked in several civilian hospital labs after getting out of the service and later in private physicians' offices. She then went back to school and got an L.P.N. degree.

We are, therefore, able to run a small clinic-type operation and to offer everything except x-rays. This office differs from the Kingman office in that I am there every day, and most of the people are seen by me. However, a few are seen by the nurse, who calls me to report her findings and get orders for treatment. She, by choice, works only five hours a day, five days a week, and I see patients by myself Saturday afternoon when I make rounds. However, we have no trouble handling our patient load, and there is hardly any day that I couldn't see a few more patients.

At times, I think the idea of a physician shortage is a big myth. If physicians would properly utilize themselves and delegate certain responsibilities, I am sure there would be plenty of physicians. By utilizing physician's assistants, I have no trouble seeing all the patients that

want to see me, and I have yet to turn a patient away or refuse an appointment because of a full appointment book.

With the ever-rising cost of health care, I think community health centers linked with clinics can diagnose and treat most medical problems on an outpatient basis and offer a means of dramatic potential to reduce the burdensome cost of hospitalization. I think insurance companies and Medicare and Medicaid are beginning to realize this and are paying for more outpatient services. I find it interesting that some

major insurance companies are paying for physical exams by paramedics, which reduces their physical exam cost. They pay 60% as much as they would for a complete exam by a doctor.

I have described the two satellite facilities in detail so as to give credulousness to my initial hypothesis that there is a vacuum of medical services that is going to be filled by somebody, and that this is a way to do it. I think it is interesting to note that it takes no new legislation to do it, and no new category of health

care provider. The physician retains the ultimate decision and responsibility for patient care, and he selects the physician's assistant that he thinks best meets the community's and his needs. To my way of thinking, the health team concept operating in a satellite office provides a vehicle through which private, organized medicine may extend its diagnostic and therapeutic powers to outlying communities and not abdicate its position to a government bureaucracy. ◀

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandro-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

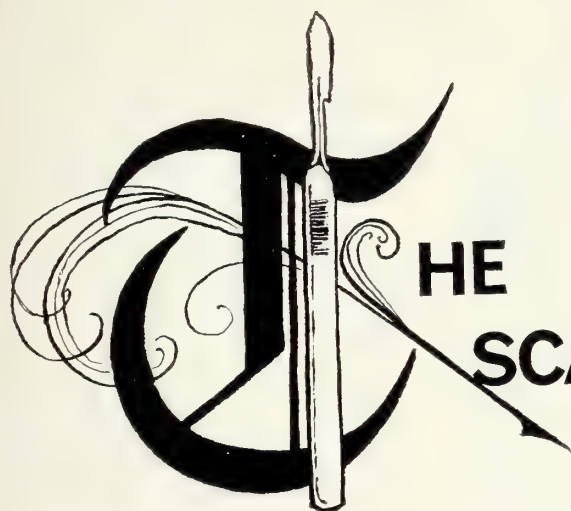
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"The history of the world is but the biography of great men."—**Heroes and Hero Worship**, Thomas Carlyle, 1841.



SCALPEL AND THE PEN

An Appreciation of Our Medical Men of Literature

II. Oliver Wendell Holmes, Physician

RODNEY A. MANNION, M.D.
LaPorte

*Ay, tear her tattered ensign
down!*

*Long has it waved on high,
And many an eye has danced
to see*

That banner in the sky; . . .

THESE lines were published on Sept. 16, 1830, by the son of an obscure clergyman in Massachusetts. He was a law student and had graduated from Harvard College in the class of 1829. The poem concerned the famous United States frigate *Constitution* which was to be dismantled in that year. The ship is moored in Boston Harbor on the Charles River today, due to the nationwide concern engendered by the poem.

The author subsequently switched after one year from law to medicine and wrote to his boyhood friend Phineas Barnes in 1831: "I do not know what you will say, but I cannot help it . . . I know I might have made an indifferent lawyer,—I think I may make a

tolerable physician,—I did not like the one, and I do like the other." He made, as history shows, the most renowned physician-writer of 19th Century America.

He was of the "best" and pure New England stock, English on the side of the Holmes and Dutch-American on the Wendell side. As he coined the phrase in his first novel *Elsie Venner*, this was the "Brahmin class of New England." His father, Abiel Holmes, was a Calvinist clergyman in Cambridge, Mass., where Oliver Wendell was born in 1809. This auspicious social origin would not perhaps presage the formation of a spirit in Doctor Holmes which, as VanWyck Brooks says in *The Flowering of New England, 1815-1856*, anticipated Sigmund Freud by 25 years.

This can be better understood at the beginning, in the house of the Rev. Abiel Holmes, minister of the First Church before its departure from orthodoxy into Unitarianism.

His father was of an amiable disposition but was devoted to the stern Calvinist doctrines of predestination and preordination. The progress of scientific and social knowledge made the young Holmes ripe for a reaction of skepticism and he kept this flame alight for the rest of his long life—always defending the humanness of humanity. He did not, however, completely lose his sense of obeisance to the Creator, for many years later he stated that he reserved a small place in his mind called "Reverence" which liked to be watered once a week by an inspired preacher. That he found them a scarce article is also true.

In the Puritan society of the 1800s an opposite ill to what is found in modern society was endemic in New England—that is, repression of the psyche. This was the land of the Salem witch trials 200 years previously. Holmes was cognizant

of these effects of sexual and other repressions and wrote three "medicated" novels dealing with schizophrenia, hysteria in an adolescent girl and a young man's morbid fear of women. The plots were more philosophical musings on case reports than genuine dramatic yarns but the local color was good and he contrived some fairly satisfactory characterizations. This doesn't lessen the pioneering psychiatric insights which they contain.

Holmes attended Harvard Medical School and spent 1833 to 1835 in Paris studying under Louis, Larrey and Dupuytren. He began private practice in Cambridge and stayed with it for 10 years with only moderate success. His biographer implies that his manner was a little flippant for that age of pompous and grave physicians but it seems possible that his mind, with its great powers, was not fully engaged in this endeavor. He was professor of anatomy at Dartmouth but had time to write a monograph in 1837 on the then prevalent malaria entitled "Intermittent Fever in New England." His great paper "On the Contagiousness of Puerperal Fever" was published in *The New England Quarterly Journal of Medicine* in 1843, thus antedating Semmelweis of Vienna by about 4 years. Some great obstetricians, including Meigs of Philadelphia, opposed the idea

but Holmes persisted quietly and republished his thesis again in 1855. He suffered none of the social ostracism that befell his Hungarian counterpart.

There was a whimsical side to this man—a gentle debunker. His writings today come through in a light and touching sense in spite of some obvious obsolescence. He was a born punster: "Why did Alexander the Great drink so much? Because he was the son of Phil-up of Macedon." Or a letter from Paris referred to "McAdam, the colossus of roads." This made him a beloved lecturer at Harvard Medical where he held the Parkman chair in anatomy from 1847 to the time, in his words, when it had become a "settee" in 1882. He made no original contributions to anatomical science but held his students enthralled by a lively delivery full of pungent metaphor and anecdotes.

He was of small stature and his lifelong asthmatic affliction limited him greatly and was partly responsible for his adherence to aristocratic New England life. He wrote, in a letter to Harriet Beecher Stowe in 1876: "... But I am a fowl that keeps his roost, and my wings are more like those of a penguin than an eagle." He interpreted the New England civilization along with Hawthorne, Longfellow, Lowell and Emerson, all the better than had he partaken of the cosmopolitan world. His powerful evoking of this limited but fruitful period might otherwise have been thinned and dissipated.

No indication of the meteoric rise of his literary reputation was evident until his friend, James Russell Lowell, the editor of a new magazine, *The Atlantic*, persuaded Holmes to write his essays published under the title *The Autocrat of the Breakfast Table* in 1858. He was then almost 50 years old. Incidentally, Holmes named the new magazine, just as he suggested the word "anesthesia" for the state induced by the new vapor, ether, as used by the dentist, Dr. Morton. The "Autocrat" was a quick and complete success and he became a literary celebrity. He thought of

himself as a poet although only his best lyric verses are free of the didactic influences of the time. His best poem, the "Chambered Nautilus," contains the lines:

*Build thee more stately mansions, O my soul
As the swift seasons roll!
Leave thy low-vaulted past!
Let each new temple, nobler
than the last,
Shut thee from heaven with a
dome more vast.
Till thou at length art free,
Leaving thine outgrown shell
by life's unresting sea!*

These are fitting thoughts for a son of New England, where the great eastern ocean is of such significance.

In later years he tried the same form of collected philosophical essays in "The Professor at the Breakfast Table" (1860) and "The Poet at the Breakfast Table" (1872), but the apogee both in prose and verse was the original.

Elsie Venner, considered the best of his three novels, appeared in 1858. Literary critics tend to disparage his novels but psychiatrists in more recent years have extolled his insights. To quote Clarence D. Oberndorf, M.D., in 1943:

Holmes tried his talents in poetry, essays and fiction but he continued first, last and forever the physician; his thinking dominated by his medical training and his daily scientific work. He was also a theological reformer, a philosopher and . . . a psychiatrist, many of whose ideas fell in line with the most advanced of this present day. In certain essentials Holmes' theory . . . is prophetic of psychoanalysis and anticipated Freud's formulations and the psychoanalytic psychiatry. . . ."

It is clear, however, after perusing these novels today, that Holmes relied basically on physiological causes for mental aberrations. For instance, *Elsie Venner* is schizoid because her mother was bitten by a snake while pregnant with *Elsie* and only secondarily because her father refused her his love. Similarly, the protagonist of *A Mortal Antipathy*, the book dealing with gynephobia, was supposed to

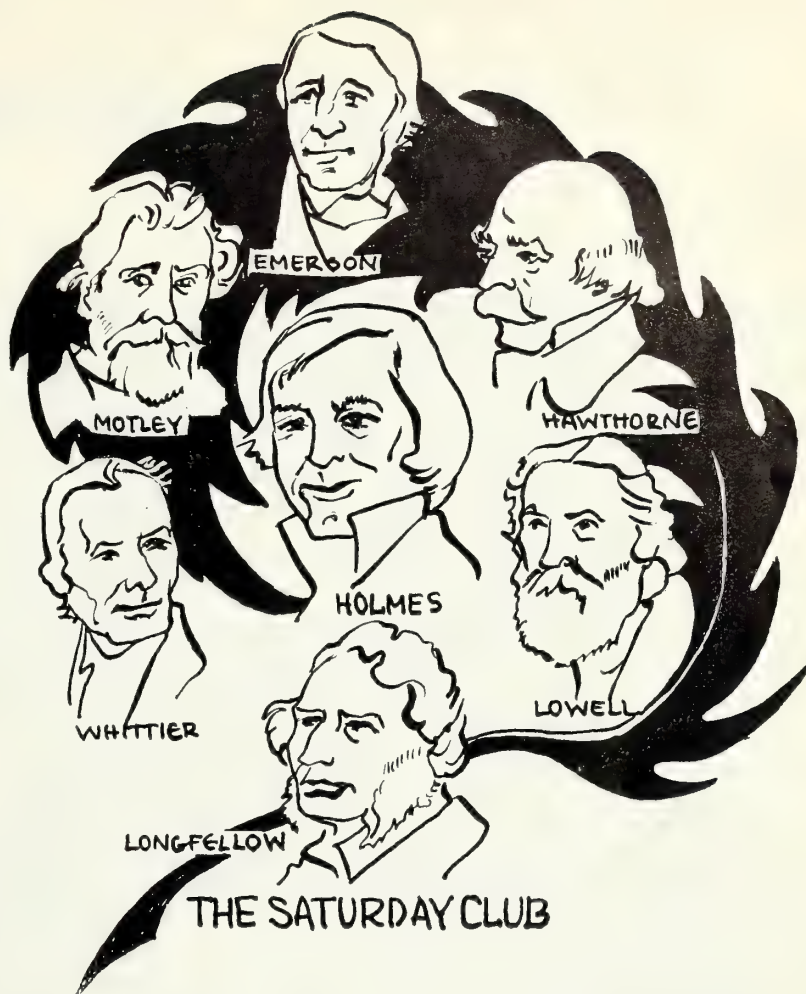


have been dropped inadvertently by a teen-age girl into a bramble bush as a child! The proponents of the new science of the last century were sometimes ensnared by these overly mechanistic causes for emotional or spiritual experience. Perhaps it has gone full circle now with new knowledge that disordered chemistry of the brain causes inherited schizophrenia.

Many readers today will confuse Dr. Holmes with his distinguished son, the celebrated associate justice of the Supreme Court of the United States. The elder Holmes married the niece of a local physician, Amelia Lee Jackson, in 1840 and their firstborn was to be the famous jurist. The latter was wounded three times in the War Between the States and only then did his father espouse actively the Abolitionist feeling which ran so high in New England with men such as Wendell Phillips. He had a lifelong aversion to politics and avoided those entanglements assiduously.

In the main, he was a physician by nature and inclination. Osler said of him in 1894: "He will always occupy a unique position in the affections of medical men . . . and as the most successful combination which the world has ever seen of the physician and the man of letters. . . ." High praise from the archetypal medical man of literature. Conan Doyle said "never have I so known and loved a man whom I had never seen." He named the greatest of fictional detectives after Dr. Holmes and even tried to save Lord Nelson's flagship H.M.S. *Foudroyant* in 1893 from a similar fate as proposed for *Old Ironsides*.

The old autocrat died in 1894 in his 85th year and was buried in Mount Auburn Cemetery along with Longfellow and others—the flower of New England civilization, born



in Calvinist probity and dying professing the transcendent brilliance of man's innate nobility. Two world wars, communistic, totalitarian governments over half the globe and the rise of the new barbarism cannot completely extinguish some of the illuminating rays which those 19th Century minds have shone over us all. Dr. Holmes, who in his amusing and capricious way was devoted to living trees for their intrinsic qualities, has expressed the superiority of honorable ideas in a characteristic manner which will close this commentary:

*There's nothing that keeps its
youth,
So far as I know,
But a tree and truth.*

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Bioequivalence

Form with fields for NAME, ADDRESS, CITY, STATE, ZIP, and a handwritten signature.

the weight of scientific opinion:

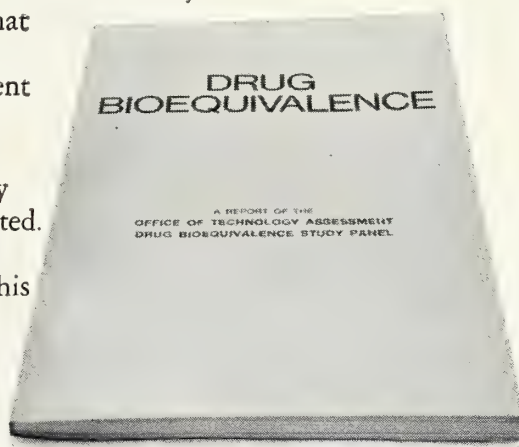
If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure

that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or
(c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

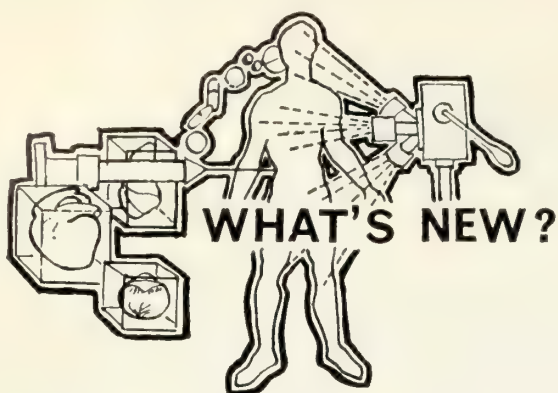
The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

protecting the integrity of your prescription



Roche's brand of amoxicillin, introduced under the brand name of Larocin, will be designated as LAROTID in the future. The name Larocin was confused occasionally with Lanoxin when written on a prescription. Roche points out that the last syllable of the new name will remind prescribers of its recommended T.I.D. dosage.

* * *

The Life Systems Division of Bourns has introduced a "Handbook of Neonatal Respiratory Care." Its 131 pages comprise original data and excerpts of information previously published by experts on neonatal care. It was published as a reference and, in addition to basic information on neonates, their problems and care, includes a comprehensive bibliography.

* * *

Para-Medical Devices has an Automated Electronic Blood Pressure Monitor which has a snap-on arm cuff with a built-in microphone which detects the Korotkow sounds and converts this signal into a flashing light which turns on at systolic pressure and turns off at diastolic pressure. The device is especially suitable for clinical use and may also be used by lay persons for monitoring blood pressure at home.

* * *

Squibb has received approval to market VELOSEF for Injection. It is the cephalosporin compound, cephadrine, which has been available for oral use previously. It is the only cephalosporin antibiotic marketed in the U.S. in both oral and injectable forms with the same chemical formula.

* * *

Orthopedic Equipment Company of Bourbon has available a new 6-page booklet on the Deyerle Total Hip Joint Replacement with replaceable liner. A major feature of this system is that it does not require the use of polymethylmethacrylate bone cement.

* * *

"The Journal of Sex and Marital Therapy" has appeared as a quarterly journal to provide a forum for the most recent clinical technics and innovative theories in this field. The publisher is Behavioral Publications. The annual subscription rate is \$15.

* * *

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Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control.

For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, peri-orbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm b.i.d. or t.i.d. depending on severity of infection.

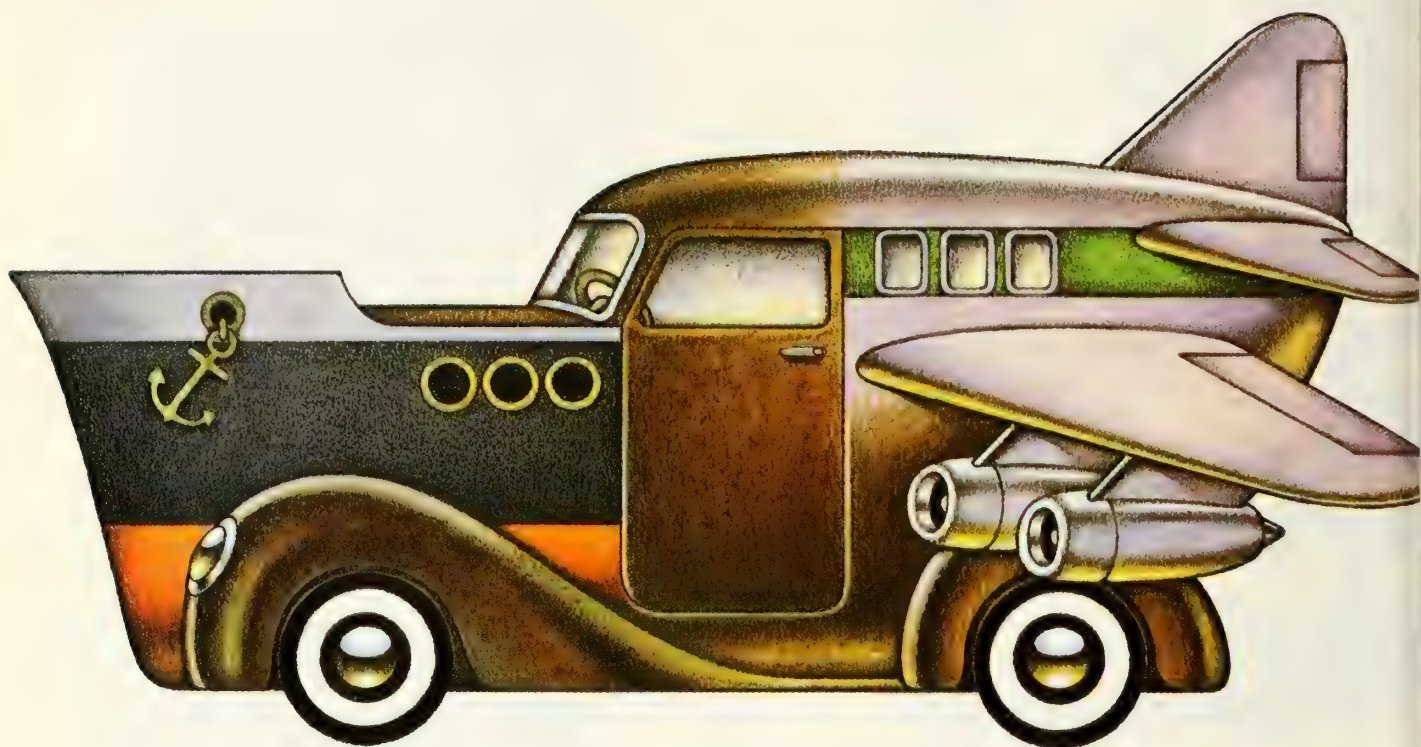
Usual child's dosage: 0.5 Gm (1 tab or teasp.) / 20 lbs of body weight initially, then 0.25 Gm / 20 lbs b.i.d. Maximum dose should not exceed 75 mg/kg / 24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole / teaspoonful.



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The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did

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Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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SEMINARS FROM RILEY CHILDREN'S HOSPITAL

The Psychotherapeutic Management of Somatic Complaints in Children

MORRIS GREEN, M.D.
Indianapolis

THIS seminar from the Riley Children's Hospital is concerned with somatic complaints such as recurrent abdominal pain, recurrent headaches and chronic fatigue presented by preadolescent and adolescent children. Although both organic and psychosocial possibilities need to be considered together, rather than separately, in the management of these somatic symptoms, differential diagnosis of organic disease will not be reviewed in this seminar. Obviously, one must be competent in such diagnosis if one is to transmit to the child and his parents (1) the feeling of confidence in their physician essential for therapeutic effectiveness; (2) maintain the requisite diagnostic open-mindedness that includes with comfort psychologic, developmental and environmental etiologic possibilities; and (3) limit the laboratory work to that dictated by clinical common sense. While a thorough history and a conspicuously meticulous physical examination can, in themselves, be psychotherapeutic, the ordering of unnecessary laboratory and x-ray

procedures obviously does not relieve the child of his complaints.

The management of somatic complaints that have a psychologic etiology depends upon the traditional competence of the physician in history taking, physical examination and counseling. History taking should be a facilitative process that enables the parents and the child to talk openly to the doctor. Through the interview, the physician attempts to understand the patient's and parents' past and current life situations—their feelings, beliefs and anxieties—while they sense the physician's expertise and interest in them as persons. This process of sharing personal facts and feelings and this mutual understanding of the patient's and family's problems leads to a diminution of their anxieties. Parents and children are helped to see linkages, if present, between the child's symptoms and the stresses he or the family is experiencing. For those parents preoccupied with their own difficulties and, therefore, unaware of their children's problems, the interview provides the opportunity to concentrate on their child and themselves in a thoughtful and, hopefully, illuminating fashion. Through the interview, his personal warmth and empathy and his capacity to understand how the patient feels, the physician also seeks to

achieve a psychotherapeutic alliance with the parents and child.

With presenting complaints of this kind, I usually open the interview with a statement somewhat as follows: "In seeing many children with this symptom, I find that it is sometimes due to physical causes, sometimes due to stresses at this stage of life and sometimes to both. But *pain is pain* no matter what the cause, so it's my practice to look thoroughly at all possibilities, physical, psychologic and . . . whatever."

This opening clarification precludes an impression on the part of the parents or child that the doctor, in a snap decision, has concluded that the symptom is all "in the child's head" or that the child is "making it up." If the parents ask about this, I usually respond with a statement such as "Well, it's not in his head, it's in his stomach."

Remembering that in the case of somatic complaints such as recurrent abdominal pain and headaches, the children are usually around 10-11 years of age or in their adolescence, and their parents are around 35 or 45 years of age, what kinds of personal, developmental or family problems and contingencies are important to touch upon in the history? The following are those considerations about which I obtain

From the Department of Pediatrics, the Indiana University School of Medicine and the James Whitcomb Riley Hospital for Children, 1100 W. Michigan St., Indianapolis 46202.

Dr. Green is professor and chairman of the Department of Pediatrics.

information in each of these cases. In my experience they are the important factors. These are easy to remember because they are things important to children in that age group.

1. Separation Experiences.

- a. The death or the anticipated death of an important family member, e.g., a parent, sibling, grandparent or friend.
- b. Divorce or anticipated divorce or desertion. An impending divorce may be suspected on the basis of the symptoms presented by the child. In view of the current divorce rate, the physician has at least a one-in-three chance of his suspicions being confirmed.
- c. Social or vocational commitments that separate parents and child.
- d. The child's fear of his own death, e.g., a child who has recovered from a critical illness or who has a long-term, life-threatening illness.
- e. Alienation or lack of communication between the patient and his family.

2. Illness in the Family.

- a. Physical illness, e.g., cancer or myocardial infarction in a parent or the presence of a long-term handicapping condition such as mental retardation or myelodysplasia in a sibling. Each parent should be asked if they are seeing a physician.
- b. Frequently there are somatic complaints in the parents. In the case of abdominal pain, a majority of the mothers have similarly characterized pain.
- c. Psychologic symptomatology and disorders, i.e., anxiety, depression, alcoholism or psychosis. Here, one may use leading questions such as "Who's the nervous one in your family?" or "Who's the worrier in the family?"

d. Hypochondriasis or parental preoccupation with illness.

3. Marital Discord.

4. Unsatisfactory parent-child interaction, e.g., over-expectation, over-restriction or unfavorable comparison with siblings.

5. How the child and his family deal with angry feelings. The outward expression of anger is especially difficulty for the child whose parent is chronically or seemingly seriously ill.

6. Evidence of depressive reaction in the child.

7. How does child get along with peers?

8. What has been the child's preparation for sexual development? His sexual concerns?

9. School and learning problems.

10. Sleeping arrangements that are not appropriate for the child's age.

11. Why do the parents come now when the complaint may have been going on a long time?

12. What do the parents and child think is wrong? If the child responds that he doesn't know, I would encourage further response by a follow-up question such as "Yes, I know, but what would you think . . .?"

13. What do the parents and child expect to be done?

14. Does the pain awaken the child at night? Generally, somatic complaints of a psychologic etiology do not.

After the work-up is complete, whether this is limited to the obtaining of the history and the performance of the physical examination, or includes, in addition, laboratory and x-ray examinations, the physician may express his findings to the parents and child in a number of ways.

(1) I sometimes put it this way: "I'm impressed that Johnny is an alert, sensitive boy. Of course, that's good and we probably wouldn't want to change that, even if we could. But, as you know, being bright and sensitive has some drawbacks. A sensitive child experiences

pleasure and beauty more readily than others, but also discomfort and pain. It's not surprising that John's digestive tract (or whatever) is also sensitive and responding 4+ to some of the pressures that you've been telling me about. From what you tell me, this tendency seems to run in your family. What we have to do here is to work on those things that are troublesome. We don't want to make Johnny less alert and perceptive, but obviously we want him to be more comfortable . . . in less pain."

With this approach and if there is open communication and the family wants to move on it, the problems, once they become evident, are usually remediable without further professional help. At other times, the physician may want to be directive, e.g., have the child return to school immediately, refer the mother for medical or psychiatric help, recommend a tutor, suggest a nursing home for a senile grandparent in the home, have the parents consider decreasing the demands they make on the child, or attempt to have them lessen their social absences. When adverse circumstances such as inadequate income, death or divorce are unalterable, the physician considers with the parent or child how a more healthy adjustment can be made to a situation that will realistically not change.

(2) In other cases, I sometimes say: "I don't know how all this got started, perhaps with some kind of viral infection or irritation, but the persistence of the symptom seems to be due to some of the things (psychosocial factors) we've been talking about."

(3) Or I might say: "I don't know if these matters (psychosocial) we've been talking about are related to Johnny's symptoms or not. I do think, however, that they're important to his development, and we ought to look into them further."

(4) Or, if the parents or child in the course of the interview raise a psychologic possibility "Could it be his nerves?" rather than pouncing

on that suggestion, I might respond like this: "Well, that's an interesting idea. You may have something there. I'd like to hear more of your thoughts and ideas about that."

This brief discussion of an approach to the management of some somatic symptoms does not permit elaboration of such special situations as those in which the doctor may expect no or only limited success, e.g., the patient sent by the school

against the family's wishes because of repeated absences, the family not ready to face their problems, the family in chaos, a parent's need to have something wrong with a child, and the like. Since a symptom such as recurrent abdominal pain offers something to the child, either in the form of primary gain, i.e., relief of anxiety; or conscious secondary gains, e.g., increased parental attention and solicitude; out of respect

for biologic homeostasis, it should not be peremptorily removed without substitution of something better. In the great majority of cases, the management of these patients is rewarding because of the good results the physician can obtain by the use of his own skills while enlisting the strengths of children and their parents in understanding and mastering the developmental stresses associated with their respective age groups. ◀

From THE JOURNAL 50 Years Ago

Explanations of the exact nature of shock are numerous and wholly at variance one with another. The acapnia theory of Henderson has few supporters, and many valid arguments have been presented to disprove the idea that a CO₂ deficiency in the blood properly explains the production of shock. Porter assigns fat embolism as a frequent causative factor, but clinical experience and experimental work will not permit this theory to stand unchanged. The exhaustion of nerve cells, supported by Crile, is now considered a secondary phenomenon and not a prime factor. The work of Cannon, Baylis, Mann and Dale seem to furnish the best hypothesis of the true nature of shock. They conceive of shock as produced by trauma, with a loss of blood volume as the essential primary phenomenon, and it is mainly upon their work that the modern conception of shock has been developed. Henderson and Crile called attention to the importance of a loss of blood volume in shock. . . .

The best known support for the view that shock is due to vasomotor exhaustion has come from the experiments of Crile, Porter and Lyon. Seelig and Mann have found that even when an animal is in extreme shock both pressor and depressor reflexes still occur. The presence of depressor effects proves that some tonic activity of the vasomotor center is still present, for otherwise its actions could not be depressed, and the pressor reflexes show that the center is still capable of increased action when stimulated. It also has been demonstrated that the vasomotor center is more capable of withstanding the adverse influence of anemia than any other of the vital bulbar centers. Every surgeon knows that splanchnic congestion is "never observed in the state of profound shock induced by an unusually severe or prolonged abdominal operation. On the contrary, the more profound the degree of shock the paler the tissues become and the pallor of the tissues and of the peritoneum is noted even when very little blood is lost." . . .

Shock always has been and still is a mysterious subject. The many theories and explanations that have been worked out and given us in the past forty years demonstrates the fact as stated above. None of the theories advocated completely and fully explain the phases of shock. In my opinion the last chapter on shock has not as yet been written. . . . "Traumatic Shock," Charles A. Weller, M.D., Indianapolis, **JISMA**, July, 1925.

SECOND ANNUAL CANCER SYMPOSIUM FOR THE PRIMARY CARE PHYSICIAN

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Seminar meetings will convene Thursday morning and continue through Saturday noon. Registrant's accommodations will be available after 2 p.m. on Wednesday. Ample time is being scheduled into the program to fully enjoy the recreation and beauty of the Inn environment. If any registrant is interested in staying at the Inn through the weekend of Oct. 4 and 5, he should make reservations at the Inn NOW for that weekend. Write to Reservations, Inn of the Fourwinds, Lake Monroe, P.O. Box 37, Smithville, Ind. 47458.

For a program brochure and registration cards for the seminar and room accommodations, clip and mail this coupon to:

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1604 N. Capitol Ave., Indianapolis
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Attention: Dr. William M. Dugan, Jr. Conference Chairman

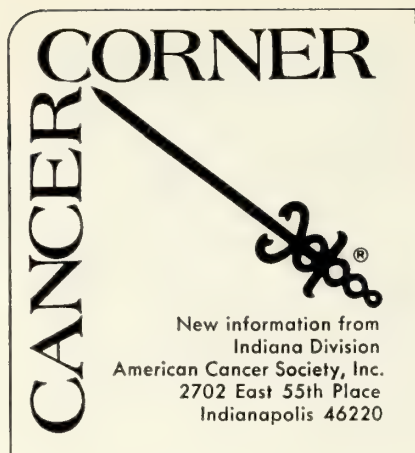
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FOR THE DOCTOR'S OFFICE—a pamphlet "If You Want To Give Up Cigarettes" can be ordered through the local American Cancer Society or by writing the above address.

RECOMMENDED READING for those who want to quit smoking—*You Can Quit Smoking in 14 Days*—Walter S. Ross—an easy-to-live-with 14 day program for cigarette

smokers who want to kick the habit. \$6.95 hardback.

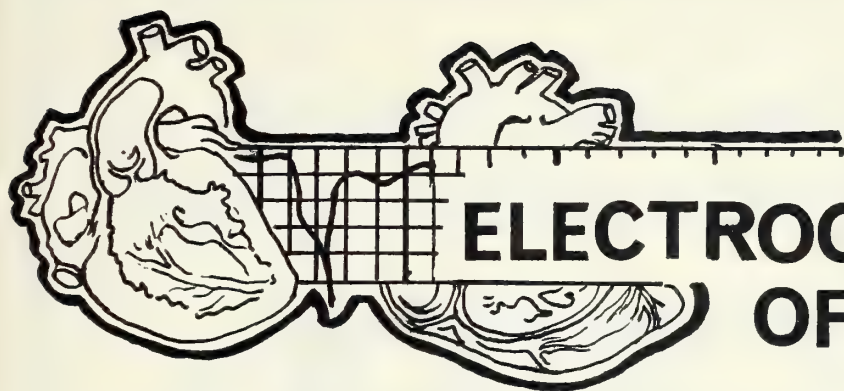
The Thinking Man's Guide to Quitting Cigarettes—Eliot Tozer—a very human approach to quitting cigarettes—from breaking the habit completely to simply smoking less. 95 cents paperback.

HCG RADIOIMMUNOASSAY

A sensitive assay for human chorionic gonadotropin (HCG) is essential to follow-up of trophoblastic disease such as hydatidiform moles or choriocarcinoma. The most sensitive pregnancy test is inadequate because it lacks adequate sensitivity. Fifty percent of choriocarcinomas are preceded by hydatidiform moles; therefore, careful follow up of these patients is essential. In those unfortunate patients who develop choriocarcinoma, chemotherapy cures 80-90%, but best results are obtained in patients followed closely and an early diagnosis made of choriocarcinoma. Unfortunately, several deaths occur yearly in Indiana from choriocarcinoma. Hopefully, with an accurate assay available on a local basis, these deaths in young women can be prevented.

Indiana University, Department of Obstetrics and Gynecology, Section of Gynecologic Oncology, through a grant from the Little Red Door Cancer Society is offering HCG radioimmunoassays free of charge to Indiana physicians, effective May 1, 1975. Any physician wishing to use this service should consult Dr. Clarence Ehrlich, Chief, Section on Gynecologic Oncology, Department of Obstetrics and Gynecology, I.U. Medical Center, Indianapolis, 46202, phone 317-264-7241.

WILLIAM M. DUGAN, JR., M.D.
Chairman of Professional Education
Indiana Division
American Cancer Society, Inc.



ELECTROCARDIOGRAM OF THE MONTH

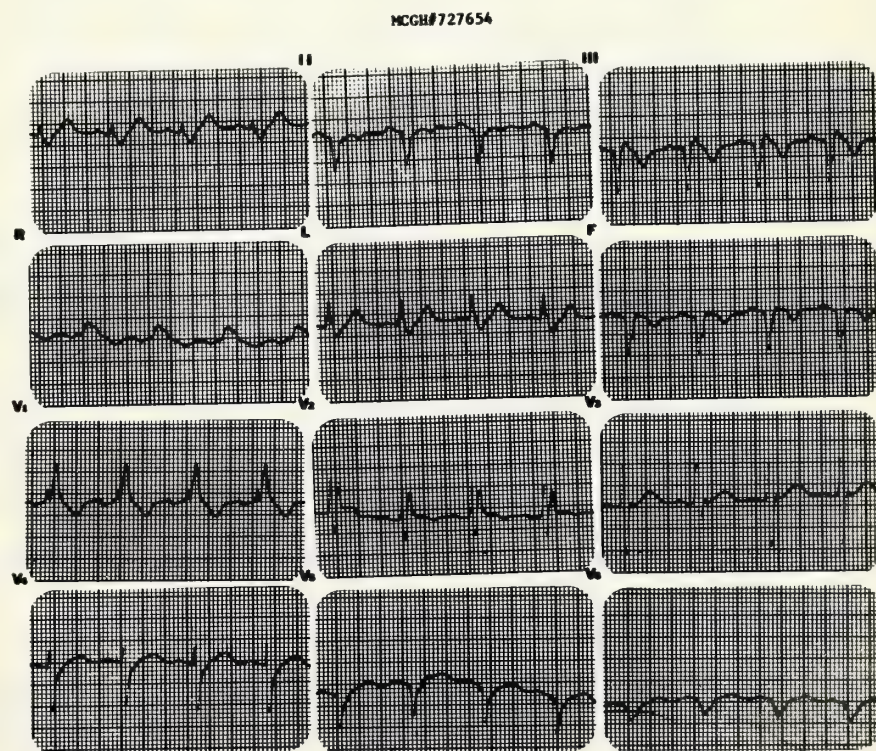
Right Bundle Branch Block

JOHN C. BAILEY, M.D.
Indianapolis

NORMAL ventricular activation proceeds via the bundle of His to the right and left bundle branches and eventually to the ventricular myocardium. A significant portion of the left ventricle is activated before the right ventricle, so the initial portion of the QRS complex is due to left ventricular depolarization. Conduction block in the right bundle branch, right bundle branch block, produces widening of the terminal portion of the QRS complex. Activation of the left ventricle is not anomalous, therefore the initial portion of the QRS complex is not distorted by the right bundle branch block. The electrocardiographic features of right bundle branch block are (1) a QRS duration of 0.12 sec. or greater due to prolongation of the terminal portion of the QRS complex, (2) a broad S wave in leads I and V_6 , and (3) an rSR' complex in lead V_1 . These criteria are present in the electrocardiogram under discussion. Note, however, that there are also abnormalities of the initial portion of the QRS complexes. Specifically, there are broad

Q waves in leads II, III, aVF, V_5 and V_6 , indicating the presence of an infero-lateral wall myocardial infarction. Because right bundle branch block distorts only the terminal portion of the QRS complex, the pathological Q waves of myo-

cardial infarction are not obscured by this conduction abnormality. Complete right bundle branch block usually signals the presence of organic heart disease, but this conduction disturbance has been reported in presumably normal individuals. ◀



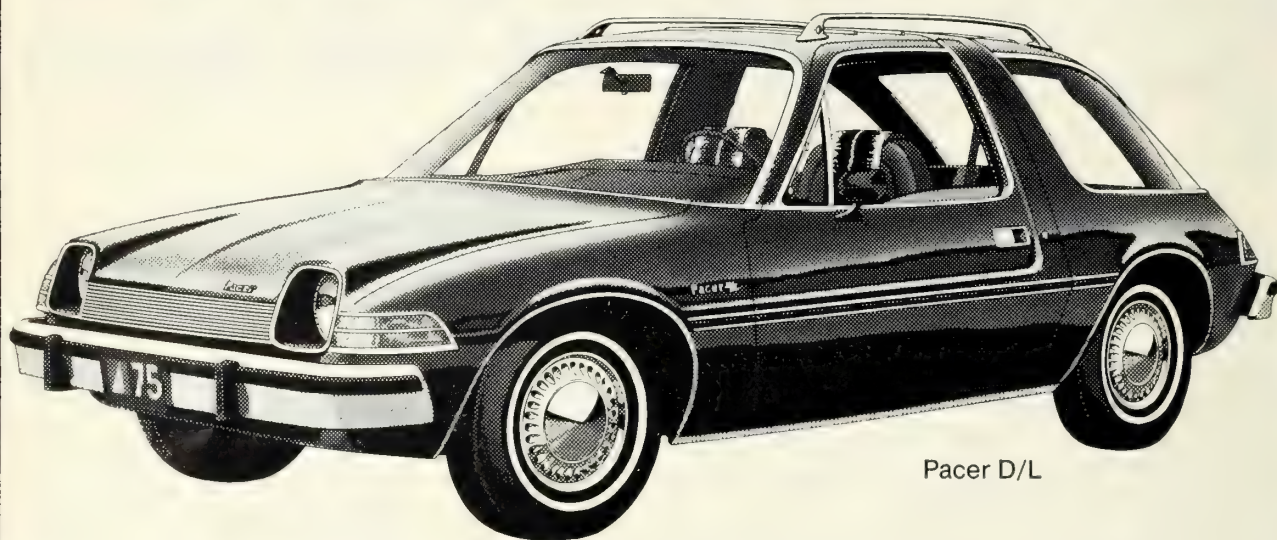
COMPLETE right bundle branch block with infero-lateral wall myocardial infarction.

From the Krannert Institute of Cardiology, Marion County General Hospital, and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

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MAC Will Make Drug Quality Secondary to Price

THE tragic effect of the "Maximum Allowable Cost" program for supplying drugs to patients of the government is that it will remove quality as the standard and replace it with price. If, as and when the program goes into full effect, price will be the ruling factor in the production of drugs; quality will, of necessity, become a secondary consideration.

The bureaucrats say that they can monitor the making of drugs sufficiently so that reliable, high quality generic forms will be assured. The inference is that some of these generic forms will be both high quality and low priced. This inference is an absurdity.

When a brand name drug has been made by its originator throughout the life of its patent the maker may be presumed to have recovered the cost of its discovery and development. At the end of its patent life the drug may be made by other manufacturers.

In a competitive economy the cost of the raw materials involved, the wages and salaries paid, the heat, light and rent and cost of distribution will be approximately the same for all those firms who produce the drug. If all the generic makers employ the same type and number of manufacturing quality checks as did the originator during

the patent-protection period, the cost to the buyer will be the same; there is no way one maker can undersell the others by any significant amount. That is, if all adhere to the proper quality checks.

A brand name drug, the proper synthesis of which entails 826 quality control tests, may be made by others after the patent expires. The generic drugs which result will cost the same unless fewer quality tests are included. The same drug made with 26 quality evaluations will cost less to make and may be sold for less. But it won't be the same drug. It will be a poor quality imitation.

When the "Maximum Allowable Cost" (low quality) program gets under way the government is going to find that, when generic drugs are of the same quality as the brand name original, the price is going to be the same.

The only way to make a drug which sells for less than its competitor is to skimp on quality.

A multiple-source generic drug, properly made, will have a uniform price, no matter who makes it.

Guest Editorials

The Physician's Assistant in Indiana

AS medical director of the Indiana University School of Medicine's Physician's Assistant

Program, I have been asked to comment on the article "Utilization of the Physician's Assistant in Indiana," contained in this issue of *The Journal*. It is with pleasure that I do so.

The survey itself was well designed to bring out the necessary data, and the 51% return attests to its ease of answer. I am sorry that the physician sample was not randomized by specialty, because distribution to those specialists who might use the P.A. in their practice (i.e., Family Physicians, Internists, and Pediatricians) would have produced a more applicable result.

The basic problem altering the answers to the survey is the present lack of knowledge of the "P.A. Concept" within the medical profession in Indiana. The P.A. concept, although now 10 years old, has spread slowly to this state, as attested by only 22 practicing P.A.s.

The statement that "At present, there is little standardization to the role of the Physician's Assistant" is incorrect. Both the American Medical Association and the Federal Government have defined the role in very distinct terms. The training programs for the P.A. are designed under "Essentials" developed by the AMA and, although there is some leeway, the rules are definite.

The conclusions of the survey bode well for the coming of the new "Mid-level Health Practitioner," the P.A., whose functions over-

lap but exceed many areas of other allied health professionals, including the nurse.

I would like to compliment the authors on a well done survey, limited by lack of knowledge on the part of the surveyed.—**Frederic L. Schoen, M.D., Fort Wayne.**

Look What's Happened to Mabel

IN the beginning, she was hired on as a receptionist, cashier-bookkeeper (for such cash as came in and such books as were kept), boiler of instruments, and general cleaning woman—at times even baby-sitter when the boss and his wife sneaked off to a meeting. Mabel had the title of "office girl" which was perhaps more accurate as to location than to age. If she lasted beyond the first week, she became indispensable if for no other reason than the fact that she was the only one who knew where things were. She came to know more about the patients in some ways than the boss did. She learned to interpret his moods (some of which she created since she was not above moods of her own) and became adept at accomplishing her ends by making him think he had thought of them first.

No one thought of calling her a "physician's assistant" although she was. She and some of the girls up and down the hall did get together and decide to call themselves medical assistants, which seemed agreeable to everyone. But the beginning of the current "physician's assistant" phenomenon occurred one day when the boss was leaving on an emergency, just as Mrs. Schmaltzenheimer arrived for her weekly Vitamin B shot and the boss called over his shoulder for Mabel to go ahead with it. No one quite recognized the seeds of change—the boss just found it expedient to pass more such activities on to her, Mabel enjoyed it, and Mrs. Schmaltzenheimer confided that Mabel hurt less than the old goat did anyway. And Mabel was into the practice of medicine. True, she was (usually) just follow-

ing orders and the boss was still responsible for the fact and the results, but it had been established that there were others besides the boss who could, if necessary, implement the mysteries and esoterica of the profession. Without formal statement, the concept developed that there was no small number of medical activities which could be accomplished by a person of reasonable intelligence and guided experience and, thereby, extend the physician's capacity to cover the territory. Even without the blessings of an action committee, the boss was willing, Mabel was willing, and Mrs. S. was willing.

It might have continued as a simple matter of convenience except for three things. First, the physician's overall success resulted in there being a lot of people around that weren't in earlier times. The physician allowed he'd one day figure out some time-saving techniques, but for the most part he just didn't give Mrs. S. as much time as she was accustomed to, and presumed she would realize his hocus-pocus was so much more effective than the hocus-pocus his grandfather had used that she was really much better off whether she saw him or not. Second, the practice of medicine was confronted with an explosive increase in the medical knowledge and application, so the physician was increasingly hard pressed to provide everything to everyone, and Mabel's assignments increased in number and technical requirement. Third, Mrs. S. noticed that she was paying a lot more for less attention and reasoned not that he was having to pay more for everything too, but that he was making more than he should and, anyway, why shouldn't it cost less if Mabel did more of it?

It is a favorite cliché of the day to note that something is "an idea whose time has come," and it appears that the physician's assistant is one of them. While the nursing profession has (in the opinion of many physicians) moved too far into the areas of administration and education, it has nevertheless also

increased the specialized professional services of its members and transferred to trained practical nurses and aides many of its earlier duties. This increasing stratification seems to be confronting the physicians too, a confrontation which disturbs many who view the trend as a threatened displacement rather than an adjunctive method for extending medical service. They point out (correctly) that only the physician can provide definitive medical care, but overlook the fact that it is exactly this feature which, if properly sustained and nourished, will assure his continued essentiality in the area of control while others carry out the provisions of the service.

The current status of the trend is uncertain as befits the practical development of an emerging concept. Particularly, it is undetermined how this extension of medical service should be accomplished and what the results will be. In theory, the physician utilizing the services of one of the several varieties of assistants—and thereby presumably having more time available—will immediately fill in that time with more of his specialized service. Human nature being what it is, however, it must be considered that to some extent it will go simply toward easing the pressures on him and permitting him to pursue other activities. Such an effect is not necessarily unsalutary—it may even result in his extending his service by living longer—but it will certainly influence the apparent efficacy of the plan. At the same time, the control he must exert over the physician's assistant and the coordination of patient care will occupy some of his time so the net accomplishment in terms of time-profit must be reckoned after these time-expenditures have been deducted.

The other presumed benefit of the plan is financial. It is reasoned that the routine and simpler duties can be detached from the physician's workload and be performed by those of lesser training at lesser cost. In other words, the patient should pay less for the combined service than he did for the physician's service alone

or get more service for the same cost, results which should be anticipated with some caution. While some patients might pay out less in the long run, it would seem probable that the total amount of health care will be larger and there is no way this can avoid increasing the total health care bill. True, the increase may be justified by saying more people are receiving more medical attention, but one is reminded of the early days of Medicare when the bills began to roll in. It was not the increased care to the elderly or his previously unremunerated services which were noted by the physician's critics, but the cost—which was attributed to the avarice of the physician (an interpretation which was abetted out of proportion, of course, by the relatively insignificant instances of true fraud). Once more, the physician is faced with the necessity of reminding society that total and ideal medical care is a laudable goal to which he has subscribed more consistently and effectively than any other group, but it won't be achieved without cost.

It appears at this point that the extension of medical service through a physician's assistant program will be pleasing to the public. It will provide perhaps a more extensive—but different—system of care. The public will be attracted by the prospect of increased medical coverage, and discount the differences this will impose since it has no way of defining these prospectively. It feels that the deficiencies of the current system were imposed on it by the physician for his own convenience and remuneration or, at least, his lack of control permitted inequities of distribution and cost. The changes that are emerging will at least be accomplished with public awareness and approval. We get the feeling the public expects the best of both worlds—the house call, the personal attention, service to the medically deprived (whether of geographic or economic origin), and so on—and at the same time, the vaunted benefits of the extensive and sophisticated medical expertise

of the day administered with financial analgesia.

Once more, the physician is faced with a public relations problem. He recognizes the value to himself and to the public of the judicious use of adequately trained and controlled personnel to assist him in his function. He also recognizes the problems inherent in providing this training and control. He must stimulate and direct the mechanics of the transition and at the same time restrain and condition the process to keep it within the limits of its intended purpose. Legislative permission is already well underway. And already some groups and individuals with limited medical training, and independent of formal physician supervision, are moving into some areas, admittedly underserved medically before, making a strong case for their value by citing patient acceptance. Once established, such individuals will be brought under physician control only at the risk of the profession again appearing self-seeking and petulant.

Perhaps we are seeing the emergence of a new and distinct stratum of medical care which will be established as a defined, respected, and productive segment of medical service. The physician and nurse have maintained a long and generally (though not always) amicable relationship based upon the concept that each has a service to provide. The physician has frequently cited the growth of medical knowledge as a drain on his physical, mental and temporal resources, which has necessitated his shortening or forsaking some phase of his service. It seems time to translate this into a system which recognizes and accepts those capable of providing these phases as respected and responsible colleagues. Antagonists will cite the current deficiencies of some of these and the injudicious independence of others as reasons to fault the whole concept. But this discounts the need for some solution, ignores the inherent and proper position of the physician to provide the training and control necessary, and denies the well-documented proof that the

individual who is given responsibility and dignity will respond creditably.

So Mabel is alive and well and loading the syringe to give Mrs. S. her shot. Her new uniform may not be a miracle fabric, but it should be serviceable and require a minimum of pressing—and should be provided by the boss.—**David E. Gray, M.D., editor, *The Journal of the Kansas Medical Society*, March 1975. Reprinted with permission.**

Editorial Notes . . .

Occasionally a child who is discovered to be not breathing may be resuscitated. One such child after being admitted to hospital had two further episodes of apnea and, in both cases, started to breathe when awakened. If an infant's lower jaw is less firmly anchored than an adult's, deep sleep may produce deep muscle relaxation and gradually increasing closing of the airway and lead to Sudden Infant Death Syndrome, according to a New Zealand researcher.

Prostaglandins, of which more than 20 have been identified in man, are the subject of widespread investigation. At the International Conference on Prostaglandins in Florence, Italy, these substances were described as "potent messenger compounds that regulate cell responses to hormonal and enzymatic stimuli." Research indicates possibility of therapeutic use of prostaglandins in control of epilepsy, heart disease, malnutrition, and aspirin-caused ulcers. One, prostaglandin E₂, is effective in inducing labor at term. It is possible that the anti-inflammatory steroids may work by inhibiting prostaglandin release. Synthesized forms have been found to be longer-acting and more selective in pharmacological effects than their natural counterparts.

Various "experts" have attempted to claim that the reduction in highway fatalities was not due espe-

cially to the 55 mph speed limit, but to less driving due to less gasoline. Gasoline has been plentiful in 1975. The number of Indiana highway fatalities up to February 16, 1975, was 99. This is an improvement over the 1974 figure of 124 which was achieved by the 55 mph limit during part of the year. The pre-55 mph record for the same period in 1973 was 185 deaths.

Drug product substitution by pharmacists has been tried in three states and in five Canadian provinces. Bruce Brennan, general

counsel for the PMA, has testified before a California Assembly committee that no consumer savings have resulted in any of these jurisdictions.

The relationship of histamine and migraine is de-emphasized by a prize-winning paper recently presented by Dr. Otto Sjaastad of Norway before the annual meeting of the American Association for the Study of Headache in Bergen, Norway. Studies, including tracing of radioactive histamine, indicate that histamine plays a minor role in

migraine and probably is much more concerned in cluster headaches.

The Little Red Door (Marion County Cancer Society) has formed an association of patients who are living active and happy lives many years after effective treatment for cancer. It is known as the "Alliance of Living Proof." Members will be presented with distinctive pins which portray a crab, the cancer sign of the zodiac, pierced by a red arrow.

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ABSTRACTS, BOOK REVIEWS

IN DEFENSE OF THE BODY, AN INTRODUCTION TO THE NEW IMMUNOLOGY

Roger Lewin, Ph.D., Anchor Press/Doubleday, Garden City, N.Y., 1974; paperback, 138 pp., plus bibliography and index, illustrated (two electron microscopy photographs plus 24 line diagrams); \$2.50.

This is manifestly written for popular consumption rather than for professional people. The subject is exceedingly complicated; while reading this book it seems even more so; and, after finishing it, one feels ready to give up and think about something else. This is not intended as a slight to the author, since he has amassed a great deal of technical material and scientific data, and is to be congratulated upon presenting this within 138 pages. But his explanations of hypotheses become confused by crosscurrents of exceptions and reference to discussions in later chapters. This makes for difficult reading, since references to earlier data, or statements, are acceptable to the reader trying to absorb new knowledge, but to refer frequently to something yet to come gives a disconcerting jolt to the stream on one's attention and throws one off the line of thought.

The author's style is somewhat colorful as applied to a scientific subject, with a tendency toward that of news reporting. At times this is refreshing, as when he states: "The buttering of bacteria with antibody so as to whet the appetite of macrophages is known as opsonization." But in other places he refers to various polemics and research programs in such phrases as "a fast-moving science," a "heated dispute," "desperate investigations," etc. On the other hand, Dr. Lewin has done thorough research along the line of the historical development in the fields of immunology and molecular biology, and this phase of the book is of great interest and importance to any student of medicine and/or history of medicine.

The last chapter, "Cancer and Transplants" is probably the best piece of reporting-on-science in the book, and worth reading by anyone interested in a brisk summing up of these fields along immunological lines.

There are 24 diagrams, but unfortunately, several of these are confusing, rather than helpful with ambiguous arrows and at least one caption containing a probable error ("antibody" instead of "antigen" in Figure 13).

The author states he has talked with "scores of research immunologists in the past year" and his book shows thoroughness of preparation. I recommend it as a refresher course for the busy doctor who likes to catch up now and then on basic research as applied to medicine.

A. W. CAVINS, M.D.
Terre Haute

NEW HORIZONS IN CARDIOVASCULAR PRACTICE

Henry I. Russek, M.D., editor; some threescore contributing authors; based on the proceedings of the William Likoff Symposium of the American College of Cardiology; University Park Press, Baltimore, 1975; 520 pages with numerous illustrations and figures; \$34.50.

While the price is a mite high, all the profits are going to the Heart Fund so that it is hard to cavil the \$34.50 figure.

The paper and printing are up to the usual high standards; I failed to note any typographical errors.

Personally, I was intrigued by the very first chapter: the Paul D. White lecture by Tsung O. Cheng on "Cardiology in the People's Republic of China": very informative and well written. Also, the mere two-page article by Dr. William Dock asking, "Is Coronary Atherosclerosis Reversible?" is a masterpiece of incisive, authoritative compression.

Each chapter is so well written and masterfully edited that it would seem invidious to comment more on one than another. This is a volume that is an imperative MUST for not only cardiologists but also all MDs whatever their specialties. Congratulations all around!

ARNOLD LIEBERMAN, M.D.
New York City

IN-HOSPITAL SUDDEN DEATH AFTER CORONARY CARE UNIT DISCHARGE

T. B. Graboys (665 Huntington Ave., Boston 02115)
Arch. Intern. Med. 135:512-514 (April) 1975.

In a retrospective analysis of in-hospital sudden death among patients with acute myocardial infarction, nine of 48 (18.7%) in-hospital deaths after discharge from the coronary care unit were judged "sudden." This group had a substantially prolonged coronary care unit course, a higher incidence of supra-ventricular and ventricular arrhythmias, and a noticeable incidence of anterior wall myocardial infarction as compared with those of a matched infarct control group. Seventy-seven percent of the sudden-death group had three or more concomitant high-risk factors as compared with only 3% of a matched control group. ◀

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President's Page

MEDICAL ETHICS

In my presidential address in October 1974, I enumerated several proposals for the Indiana State Medical Association to consider and execute. The first proposal concerned the attenuation of the malpractice insurance problem; the state legislature has recently enacted House Bill 1460 as an initial resolution of this issue.



The second of my four major propositions has led to the formation of the Medical Ethics Committee. This committee has become even more important since the passage of the Medical Practice Act during the last legislative session. This law (House Enrolled Act 1698), took effect July 1, 1975, and provides for a medical licensing board appointed by the governor composed of five M.D.'s, one D.O., and one chiropractor. This board will have the power to issue, suspend and revoke the Indiana medical license of medical and osteopathic physicians; the article specifically excludes other professionals, including chiropractors.

Among other stipulations, this act holds that a license will be revoked for the "willful or wanton misconduct . . . in the practice of medicine . . ." Violations of the actions of the Board may bring a two to ten year imprisonment and/or a \$1,000 to \$5,000 fine. With such a forceful approach, I hope that we do not develop "a system of ethics compounded of misanthropy" as alluded to in the writings of Macaulay, but rather a system embodying constructive criticism and personalized assistance. It is for this reason that the Medical Ethics Committee was formed.

The stated purposes of the Committee are to investigate matters concerning medical ethics and professional relationships, and to advise and counsel members of the Association in these matters. The Committee's recommendations and deliberations are confidential and serve primarily for guidance, with the reserve power to present evidence to the Board of Trustees when it is felt that action is warranted.

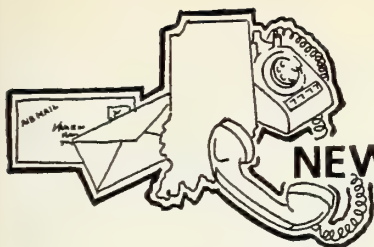
In the face of legislative ethics, with its intended public discussions for which the Medical Practice Act provides, the Medical Ethics Committee could, in addition, serve in a "watchdog" capacity to investigate rumors and reports of unethical conduct throughout the state.

As I have stressed in my previous communications, the catchword of my term is "teamwork." In the area of medical ethics I believe that it is not only teamwork with the state government, but also, of most importance, teamwork among the physicians themselves. I hope that all Indiana physicians are aware of the presence and function of the Medical Ethics Committee. If any county society, physician, or person wishes to utilize this committee, notify the Medical Ethics Committee, which is part of the Grievance Committee of the Indiana State Medical Association. I am convinced that this Committee is an essential asset to our Association.

A handwritten signature in dark ink, appearing to read "Gilbert M. Wilhelmus". The signature is stylized with a large, sweeping initial "G" and a long, horizontal flourish extending to the right.

Gilbert M. Wilhelmus, M. D.
President

Indiana State Medical Association



NEWS NOTES

Continuing Medical Education

The following Indiana physicians have received the AMA Physician's Recognition Award within the past few months:

Drs. Roger Allen Reimers, Bloomington; Harold D. Caylor, Jack T. Collins and Alberto Waksman, Bluffton; Louis D. Bojrab, Carmel; Larry Gale Willhite, Columbus; Larry L. Cox, Herman F. Rusche, Charles M. Sinn, William T. Weathers and Young S. Yim, Evansville; John Edward Moenning, Greenfield, and Isadore E. Friedman, Hammond.

Also, Drs. Gilbert H. Barnes, Alfredo B. Gonzalez, James V. Grief, Lewis E. Morrison, F. Michael Mullinix and Eugene D. VanHove of Indianapolis; Harry D. Heideman, Jeffersonville; Lindley H. Wagner, Lafayette; Leon N. Young, LaPorte; Mathikere R. Rajachar, Marion; Elbert L. Tetrick, Portage; Frank B. Adney and Richard M. Butler, Richmond, and M. Samir Bawab, South Bend.

Physicians earning the award in May were: Drs. Gonzalo T. Chua, Beech Grove; Michael Z. Silbert, Bloomington; Armando E. Angeles, Connersville; Tsutomu T. Suzuki, Covington; Harry L. Holwerda, DeMotte; Mars Benton Ferrell, Fortville; Donald E. Lacera, Hammond; Allen D. Scales, Huntingburg; Girdhar L. Ahuja, Joseph M. Daly, James H. Gosman, Fred A. Hendricks, Frederic P. Hibbeln, Young L. Kim and George A. Rowe, Indianapolis; Charles N. Patton, Lafayette; Frank H. Zahrt, LaPorte; Henry S. Riley, Madison; William V. Hehe-mann, Munster; Lawrence K. Hussey, South Bend, and Larry G. Cole, Yorktown.

Rehabilitation of Spinal Injury Cases Subject of 16 mm Film Titled "Changes"

Rehabilitation of spinal cord injury cases and their successful return to useful lives is the subject of a new 16mm sound and color motion picture entitled "Changes." The film is presented by the Craig Rehabilitation Hospital. The 27-minute film is available on free loan to hospitals, medical centers and interested business organizations. Requests to Modern Talking Picture Service, 2323 New Hyde Park Road, New Hyde Park, N.Y. 11040.

Pamphlet on VD Among Teenagers Offered

Public Affairs Pamphlet No. 517 is entitled "VD—EPI-DEMIC AMONG TEENAGERS." It discusses symptoms, treatment and prevention in nontechnical language. Available at 35 cents per copy from 381 Park Avenue South, New York City 10016.

Offer New Publication on Fire Protection by Halons

A new publication, "Fire Protection by Halons," is available from the National Fire Protection Association. The book explores Halon properties, testing, application, equipment and design criteria. Halons are useful in controlling a wide range of special fire hazards. The book is priced at \$4.75. The Association address is 470 Atlantic Ave., Boston 02210.

Continued

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Air Force Medicine



"TO BETH WITH LOVE"—Highlight of the annual meeting in May of the Woman's Auxiliary to the ISMA was the presentation of a handmade quilt to outgoing president Mrs. Beth Bowen, shown here with Mrs. Robert C. Stone, Ligonier (left), president of the Noble-LaGrange Medical Auxiliary. The quilt was planned, pieced and quilted by the Noble-LaGrange Medical Auxiliary under the leadership of Mrs. Allen Martin, Shipshewana, and Mrs. Kenneth Lehman, Topeka. A 10 x 10-inch white square was sent to each county in Indiana where there is a Medical Auxiliary, and the blocks depict unique local landmarks, flowers, birds and trees, showing much ingenuity and variety. Forty people, ranging in age from eight to eighty-five, did the quilting. Put together with blue strips and having a wide blue border, the quilt bears across the top Mrs. Bowen's motto for the year: "A task worth doing, friends worth having, make life worth living." (Cromwell Advance photo—Jim Wallace)

Hemophilia Committee Named

Drs. Cornelius Healy, Evansville, Victor H. Muller, Indianapolis, Robert Seibel, Nashville, and William J. Pierce, Bruceville, are among those who have been named by **Governor Otis R. Bowen** to an advisory committee for a new state hemophilia program to provide treatment for hemophilia victims unable to pay the entire cost of treatment.

Elected Junior Fellow Vice-Chairman

Dr. Philip N. Eskew, Jr., Indianapolis, was elected vice-chairman of the Junior Fellow Division of the American College of Obstetricians and Gynecologists at the group's recent annual meeting in Boston. He will complete his second year as District V Chairman of the Junior Fellows at the annual district meeting in Toledo in September.

Dr. Schoen Receives Bibler Award

Dr. Frederic L. Schoen, Fort Wayne, has received the first annual Lester R. Bibler Award for his outstanding contribution to family practice.

The award is to be given each year by the **Indiana Academy of Family Physicians** to an Indiana doctor who has significantly contributed to the practice of medicine.

Medical Assistant of Year Named

Patricia "Penny" Scubelek, Crown Point, a busy laboratory technician, doctor's business manager, wife and mother, has been named **Indiana Medical Assistant of the year** by **Blue Cross and Blue Shield of Indiana.**

Mrs. Scubelek became the second annual winner at the recent state convention of the **Indiana Chapter of the American Association of Medical Assistants** held at Clarksville.

She is employed by **Thomas P. Konicke, M.D.,** a Chesterton physician.

The award exemplifies the most experienced, dedicated, and active **Indiana medical assistant** in performance of her duties in a doctor's office.

Deaconess Hospital Staff Elects

Charles W. Hachmeister, Evansville, was chosen president-elect of the **Deaconess Hospital** medical staff recently. The new president is **Dr. Leo R. Nonte.**

Dr. Ned P. Rule was reelected secretary-treasurer. **Drs. Stephen E. Braun, John P. Longstaff and Herman F. Rusche** were elected to the **Executive Council** of the medical staff. Continuing on the council for a second year are **Drs. Edward L. Brundick, Irvin L. Heimburger, and L. John Vogel.**

Tips on Eye Care Offered in Film

A new film which offers tips on eye care is announced by **Association Instructional Materials of New York City.** It is a fully animated and lively cartoon on the do's and don'ts of eye care and is available for sale or rental. It is suitable for audiences of all ages.

Psychiatrists Honor Dr. McAtee

Dr. Ott B. McAtee, superintendent of **Madison State Hospital,** was honored at the annual meeting of the **American Psychiatric Association** in California recently.

The rank of **Life Fellow** was conferred upon Dr. McAtee in recognition of his 30 years of active membership in the association.

Dr. McAtee is a past president and current secretary-treasurer of the **Jefferson-Switzerland County Medical Society** and also is a delegate to the **ISMA** annual meeting. He has been superintendent of the hospital since 1952, guiding it through periods of great change.

Guide to Abortion Law Published

The **American Civil Liberties Union Foundation** is distributing a **"Doctor's Guide to Abortion Law."** Copies have been mailed to all the **Fellows of the American College of Obstetrics and Gynecology.** Additional copies are available for **50 cents per copy.** The address is **22 East 40th St., New York City 10016.**

Dr. Isidore Mandelbaum Devises Teaching Aid for Breast Cancer

Dr. Isadore Mandelbaum, I. U. School of Medicine, Indianapolis, has devised a replica of the female breast to be used in teaching students the technic of breast examination and the tactile characteristics of various lesions. In addition, it has been found valuable in teaching women the art of breast self-examination. The simulator has been recommended by the National Public Education Committee of the American Cancer Society for use throughout the country. The popular name of the replica is BETSI, which is the acronym for Breast Examination Tactile Simulator Instructor.

Medals for 50-Year Insulin Users

Eli Lilly and Company will present silver identification medals to those diabetics who have maintained themselves on insulin for a half-century or more. Eli Lilly, honorary board chairman, has written each recipient to assign "most of the credit for attaining successful control of diabetes because in this disease a significant amount of the responsibility for proper therapy is placed upon the individual patient."

Dr. Pizzo Receives Humanitarian Award

Dr. Anthony Pizzo, Bloomington, who served as a state representative in the Indiana General Assembly this year, received the Humanitarian Award for outstanding health service by a physician at the annual Health Services Recognition Awards meeting at the Bloomington Hospital recently.

Mrs. Frank N. Hrisomalos, chairman of the Meals on Wheels service, received the Quality of Life Award as the individual most responsible for initiating a new service.

Kirtley Award Winners Named

Wabash College announces that **Joel A. Porter**, of Cincinnati and **Gregory L. Hilbrich** of Saratoga Springs, N.Y., have received the James Marion Kirtley Award of the Wabash College chapter of Kappa Sigma in recognition for their first semester scholarship. The Award is named after **Dr. James M. Kirtley**, in active practice of family medicine in Crawfordsville.

Dr. Stoltzfus Serving in Haiti

Dr. Glenn Stoltzfus, Goshen, leaves this month for Haiti for a year of service in Hospital Albert Schweitzer. His wife and two sons will accompany him.

"Drugs—Use, Misuse, Abuse" New Public Affairs Pamphlet

The latest Public Affairs Pamphlet is No. 515. It deals with "Drugs—use, misuse and abuse, guidance for families." Written by Margaret Hill, it outlines how a family lifestyle, with use of caffeine, nicotine, alcohol, aspirin, tranquilizers and sleeping pills, all ordinarily considered normal in moderate amounts, may influence the habits of children. The price is 35 cents. Address is 361 Park Avenue South, New York City 10016.

Dr. Ferguson Participates in Seminar

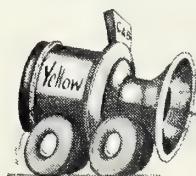
Dr. Stephen C. Ferguson, Evansville, participated in the Second International Symposium on Plastic and Reconstructive Surgery of the Head and Neck which was held in Chicago recently.

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Eli Lilly and Company announces a donation of antibiotics, vitamins and analgesics to the value of more than \$50,000 wholesale to the American Korean Foundation, the Catholic Medical Mission Board and World Vision, all three being relief organizations presently assisting South Vietnamese orphans and refugees.

Mrs. Frank Green Honored

At the recent meeting of the House of Delegates of the auxiliary of the Indiana State Medical Association at Goshen, Mrs. Frank Green of Rushville was presented the Woman of the Year award for 1975 for outstanding work in the Art of Journalism. Mrs. Green is state editor of *Hoosier Doctor's Wife* and a feature writer for the national publication *MD's Wife*. Her story "Women United Against Rape" which appeared in the March issue of *MD's Wife* was reprinted by the American Dental Association in its June issue.

Gives View of Learning Disorders

Dr. Hyman L. Cohen, Gary, was the featured speaker at a recent meeting of the Porter County Chapter of the Association for Children with Learning Difficulties.

Booklets on Fire Protection In Health Care Facilities

"Health Care Safety—Private Fire Brigade" is a collection of 13 publications on fire protection in hospitals, nursing homes and clinics. It is available from National Fire Protection Association, 470 Atlantic Ave., Boston, Mass. 02210. Emphasis is on fire fighting, fire isolation and fire prevention. The publications are packaged in an attractive desk case and may be purchased for \$37.



MR. JAMES A. WAGGENER, executive secretary of the Indiana State Medical Association, looked on with satisfaction as Governor Otis R. Bowen affixed his signature to Indiana's new Medical Practice Law. The law was published in its entirety in the June issue of THE JOURNAL.

Fire Protection Association Offers Booklet Titled "Operation Skyline"

The National Fire Protection Association has published a book titled "Operation Skyline," a new guide to pre-fire planning for high-rise offices and apartments. Sample safety and evacuation plans are outlined in detail. The book is priced at \$3.25. Address is 470 Atlantic Ave., Boston, Mass. 02210.

Hartford Foundation Funds I.U. Research

The Hartford Foundation, during 1974, made grants totaling \$192,622 to Indiana University School of Medicine to cover present and future expenditures on research entitled "A search for evidence of cytoplasmic inheritance in man."

Exhibit Takes National Honors

Donald Schauwecker, a third year medical student at Indiana University School of Medicine, has been selected as a finalist in a scientific exhibit competition sponsored by E. R. Squibb & Sons, and the American Medical Student Association. Schauwecker's exhibit took second place honors and will be shown at the AMA meeting in Atlantic City. Mr. Schauwecker is the son of Dr. Cleon M. Schauwecker of Greencastle, Trustee of the Fifth District.

Ninth International Symposium Sponsored by Miles Laboratories

The Ninth Miles International Symposium was held at The Johns Hopkins Medical Institutions, Baltimore, June 4 to 6. As in the previous meetings, the program was participated in by worldwide authorities. The subject this year was "Cell Membrane Receptors for Viruses, Antigens and Antibodies, Polypeptide Hormones and Small Molecules."

New Steroid Hormone Antisera Available

Miles Laboratories announces additions to its family of antibodies to hormones which are used in radioimmunoassay techniques. The three new hormone antisera are: Estrone-6-thyroglobulin, 5alpha-Dihydrotestosterone-1-BSA, and 20alpha-Dihydroprogesterone-3-Thyroglobulin.

Dr. Clark Awarded Fellowship

Charles M. Clark, Jr., M.D., associate professor of medicine and pharmacology, I. U. School of Medicine, is the recipient of one of six awards made by the Robert Wood Johnson Foundation for a Health Policy Fellowship which includes a year's study and congressional work assignments in Washington during 1975-76. Each of the six recipients is described as an outstanding mid-career professional working in an academic health setting.

Nursing Home Fire Safety Booklet Developed for Employee Training

"Fire Safety for Nursing Home Employees" is a new training course developed by the National Fire Protection Association in cooperation with the American Nursing Home Association. It is designed for the training of employees. The learning package consists of a 69-page Instructor's Manual plus 10 copies of a 43-page Employee's Workbook, coordinated with the manual. The package is priced at \$23.50. Additional student workbooks are \$15.50 per package of 10.

Gary Physician Visiting China

Dr. Wei-Ping Loh, Gary, is one of four American physicians who, on invitation by the People's Republic of China, are visiting medical and research institutions in Peking and Shanghai this summer. Dr. Loh will return to the U.S. the latter part of July.

Purdue Creating Cancer Research Center

A Cancer Research Center will be created at Purdue University by a grant from the National Cancer Institute. The grant is the first payment on an appropriation to support two years of planning. The center will be broadly interdisciplinary, involving at the outset research personnel in biology, chemistry, medicinal chemistry, biochemistry, animal science, veterinary medicine, botany and plant pathology.

Receives Fifth Annual Ritchey Award

Dr. Kenneth G. Kohlstaedt, Indianapolis, retired vice-president of medical research for Eli Lilly and Company, received the Ritchey Recognition Award at the fifth annual **James O. Ritchey** Recognition Day program at the Methodist Hospital, Indianapolis, last month.

The award is given annually to an alumnus of the Indiana University School of Medicine who has made significant contributions in his field.

I.U.M.C. Film Salutes Bicentennial

Indiana University School of Medicine has produced and has for sale or rent a 29½-minute, color film on the history of medicine in Indiana. Titled "Wisest Man in the Valley," the film was produced as a salute to the Bicentennial Celebration. It is appropriate for all types of audiences. Write to Medical Educational Resources Program, 1100 W. Michigan St., Indianapolis 46202.

Dr. Russell Havens Retires

Dr. Russell E. Havens, Fort Wayne anesthesiologist retiring from practice, was honored by a group of friends, colleagues and family members at the Fort Wayne Country Club recently. For 15 years Dr. Havens was in general practice in Arcadia. Following World War II Dr. Havens took residency training in anesthesiology at the Hines Veterans Administration Hospital and began his practice in Fort Wayne in 1947.

Pamphlet Discusses "Sex After 65"

"Sex After Sixty-Five" is the title of Public Affairs Pamphlet No. 519. The author attacks many outdated ideas on the subject and outlines a program for public education. The pamphlet is sold for 35 cents. Address is 381 Park Avenue South, New York City 10016.

Dr. Maxam Elected Vice-President

Dr. B. T. Maxam, Indianapolis, a 1947 graduate of Butler University, has been elected vice-president of the Butler University Alumni Association.

Herbert P. Dixon, Blue Shield vice-president, is serving as president and as chairman of the alumni association's annual fund drive this year.

Pamphlets Now Available in Braille

Tel-Med pamphlets are now available in Braille. For further information, phone or write Indiana Rehabilitation Services, 536 West 30th St., Indianapolis 46208.

Dr. Joe Black Reelected Chairman

Dr. Joseph M. Black, Seymour, has been reelected chairman of the Board of Directors of Blue Shield of Indiana.

Prize Contest Announced

The American Academy of Orthopaedic Surgeons announces a manuscript prize contest with three Kappa Delta Awards of \$2,000 each to be awarded, one each to articles on (1) basic research that relates to the musculoskeletal system, (2) clinical research in orthopaedic surgery, and (3) problems related to trauma of the musculoskeletal system. The deadline is August 1. For full details write the Academy at 430 N. Michigan Ave., Chicago 60611.

Dr. Heritier Named to Board

At the fourth annual business meeting of the Board of Directors of the American Academy of Stress Disorders in Chicago recently, **Dr. C. Jules Heritier, Columbia City**, was elected to the Board.

Community Honors Dr. S. M. Casey

Dr. Stanley M. Casey, Huntington, was honored at a recent party noting his 50 years of service to the community. A graduate of Indiana University Medical School with the Class of 1921, Dr. Casey is a Senior Member of the Indiana State Medical Association.

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**ARNOLD H. KAMBLY, M.D.
Psychiatrist-Director**

Medical Staff Listing Correction

The listing of officers of the University Heights Hospital, Indianapolis, in the April issue was incorrect. The following is the correct list for 1975: Dr. William H. Fulton, president; Dr. Steven D. Atkins, president-elect; Dr. Alfredo Gonzales, secretary-treasurer; Drs. Bruce Bender and C. W. Dill, members-at-large.

Monitoring System Brochure Offered

Scientific Research Instruments Corporation has a new 12-page brochure describing a non-invasive respiratory intensive care monitoring system that can provide an early indication of deterioration in the pulmonary status of up to 12 patients. It is entitled "The Medspect RICS WATCH." For a copy write to Dept. MRW of the Corporation, 6707 Whitestone Road, Baltimore, Md. 21207.

Market Commentary

Recent irregularities in the stock market have again brought up the specter of a possible secondary reaction; continue to buy and hold common stocks, but be very cautious and selective in all new purchases.

CURRENT TREND ANALYSIS

A Full Scale Reaction Could Last 30-90 Days

If a full scale secondary reaction is finally developing, it could last from 30 to 90 days and carry the Dow down 100 points or so.

This would be a normal reaction period and depth and while all indications a month ago also pointed in the same direction and a rally developed instead, the market is now higher and technically weaker than it was then.

That suggests that the possibilities of a full secondary reaction now are greater than a month ago. Further, it is not unusual for a "false" reaction to precede the real thing about 30 days or so.

In any event, this is certainly the time to use utmost caution and any buying that is done should be confined to those issues which have not had big run-ups already this year like Consolidated Foods, Union Bancorp, Scott Foresman and Amfac.

CURRENT STOCK SELECTIONS

Major Buying Opportunity

Such a secondary reaction as being visualized here could prove to be a major buying opportunity and we recommend clients plan to use it for just exactly that, should it develop.

Last December we published a Forecast entitled "A Bottom Area" a week after the actual bear market bottom.

Whether we can come that close again is for the future to tell, but the Dow Theory often does give helpful indications at secondary reaction bottoms.

Such reactions are entitled to a one-third to two-thirds correction of the previous rise. A one-third correction of the rise to date would bring the Dow down to around 750. Anything in that area or below should be considered a prime buying area.

As far as individual stocks are concerned, we are following several companies closely as possible new additions to our recommended lists should they drop into better buying area.

But our successful recommendations of last fall and winter—several of which have made spectacular gains—also remain among our prime buying candidates.

Any reaction that carries issues like RCA, Searle, Taft Broadcasting, McGraw-Hill, IBM, Dow Jones & Co., Bell & Howell, Outboard Marine and Allied Chemical down with it will simply add to their already high attraction as buying candidates.

Failure of the secondary reaction to develop and then a rally to new highs by both averages will, of course, change all this and suggest another upward surge in the market to perhaps the 900 area.

Conclusions

The market has had several false secondary reaction starts and this could be another. But after a rally of over 250 points, clients should be very cautious. Only new highs will eliminate the good possibility of a quite severe reaction in this area. **from Dow Theory Forecasts, May 26, 1975. Reprinted with permission.**



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FUTURE MEETINGS, SEMINARS, COURSES

Cost Containment in Hospitals Subject of Michigan Conference

A conference on "Cost Containment in Hospitals" will be conducted at The School of Public Health, University of Michigan, Ann Arbor, on July 21 to 25. Specific methodologies and examples of major cost reductions through the implementation of improved systems will dominate the program. "Cost Containment" is expensive—the registration fee is \$300. Write Walton M. Hancock, School of Public Health, Third Floor, Francis Bldg., 109 Observatory, Ann Arbor, Mich. 48104.

Clinical Anesthesiology at Lexington

"Scientific Foundations for Clinical Practice" will be the theme for a continuing education course at the College of Medicine, University of Kentucky, Lexington, September 26 to 28. The registration fee, which includes a banquet on Friday, is \$45.00. The material is especially adapted for the nurse anesthetist and for the general physician who administers anesthetic agents. For information write Dr. Frank R. Lemon, College of Medicine, Lexington, Ky. 40506.

Symposium of Polytomography Of Temporal Bone Announced

The 12th two-day Symposium on Polytomography of the Temporal Bone will be given under the auspices of The Wright Institute of Otology at Community Hospital, Indianapolis, on Sept. 27 and 28.

Subjects covered are: "Basic Anatomy of the Temporal Bone" and "Technique of Polytomography of the Temporal Bone" with demonstrations of normal tomograms. Pathological conditions revealed by polytomography, such as cholesteatoma, ossicular chain problems, otosclerosis, fractures, foreign bodies, tumors and congenital anomalies are shown on original tomograms and the clinical applications discussed.

Number of registrants is limited to 18. Fee for the course is \$250.

Inquiries should be directed to: The Wright Institute of Otology, Inc., Community Hospital of Indianapolis, Inc., 1500 North Ritter Ave. Indianapolis 46219.

Purdue University Sponsoring First Cardiac Defibrillation Conference

A Cardiac Defibrillation Conference, the first of its kind, will be conducted at Purdue University on Oct. 1. Technics will be presented and examined critically. A major goal of the three-day meeting will be to integrate all available technology for optimization of ventricular defibrillation. For further information write to Dr. W. A. Tacker, Electrical Engineering Bldg., Purdue University, W. Lafayette, Ind. 47907.

60th Scientific Assembly to Be Held by Interstate PG Medical Association

The 60th Annual International Scientific Assembly of the

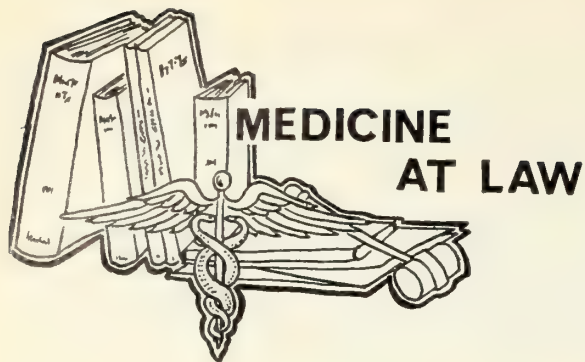
Interstate Postgraduate Medical Association will be held at the New Orleans Marriott Hotel, Nov. 3 to 6. It provides 20 hours of prescribed credit for members of the American Academy of Family Physicians. A similar credit applies to the AMA Physician's Recognition Award. Program outline and hotel rates may be obtained by writing to the Association at P.O. Box 1109, Madison, Wis. 53701.

Eye and Ear Infirmary Schedules Course In Laryngology, Bronchoesophagology

Nov. 3 through 8, 1975, are the dates for a continuing education course in laryngology and bronchoesophagology to be conducted by the Department of Otolaryngology, Abraham Lincoln School of Medicine, University of Illinois, and the Eye and Ear Infirmary of the University. Dr. Paul H. Holinger will direct the course and the registration will be limited to 20 physicians. Write to the Department of Otolaryngology, 1855 West Taylor St., Chicago 60612.

I.U. Medical School Announces 1975-76 Continuing Medical Education Calendar

Aug. 6, Sept. 25,	Strabismus Symposium, Advances in Clinical Cancer Treatment,	Bloomington Evansville
Sept. 30-Oct. 2, Oct. 9, Oct. 29, Oct. 31-Nov. 1, Nov. 5, Nov. 5-6, Nov. 12, Nov. 14-16, Nov. 19-20, Nov. 19, Dec. 3, Dec. 4, Dec. 17, Jan. 15, Jan. 21, Jan. 29, Feb. 11, Mar. 10-11, Mar. 18, Mar. 17-19, Mar. 22-26, April 7, April 28, April 29-30, May 5-6, May 5-6, May 8, May 20-21, May 20-22,	Advanced Echocardiography, Clinical Rheumatology, Clinical Endocrinology, Nuclear Technology, Symposium on Lymphomas, Critically Ill Child, Neuro-Ophthalmology, AUA Review, Ob-Gyn, Contact Lens, Pediatric Management, Gastrointestinal Emergencies, Office Orthopaedics, Lung Diseases, Infectious Disease, ENT Workshop, Arthritis Symposium, Internal Medicine Review, Antimicrobial Therapy, Radiology of Trauma, Pulmonary Course, Neuro-Diagnostic Techniques, Anesthesiology for G.P., Clinical Use of Red Blood Cells, Child Care Conference, Clinical Electrocardiography, Emergency Care, Gynecologic Cancer, Clinical Applications of the Gamma Scintillation Camera, Family Review I, Family Review II, Head and Neck Otolaryngology,	Indianapolis Richmond IUSM IUSM IUSM Stouffers Indianapolis Indianapolis Indianapolis IUSM Richmond IUSM Richmond IUSM IUSM Indianapolis Indianapolis Richmond Indianapolis Indianapolis IUSM IUSM Indianapolis Indianapolis IUSM Lafayette IUSM IUSM Indianapolis Indianapolis IUSM
June 8-10, July 6-8, July 12-23,		



Physician Convicted of Violating Dangerous Drug Act—Evidence that a physician had sold dangerous drugs in bad faith was sufficient to support his conviction for violation of the Dangerous Drug Act, an Indiana appellate court ruled.

A police informer made four visits to the physician's office during one week, purchasing over 80 pills containing amphetamines and barbiturates. Each of the envelopes containing the pills was labeled with the recommended dosage of "1 tablet 2 times a day."

The State brought an action against the physician, charging him with violation of the Dangerous Drug Act. He was convicted and sentenced to a term of 180 days at the State Farm and a fine of \$500.

The Act provides that sale of any dangerous drug is unlawful unless it is delivered by a practitioner in good faith in the course of his practice. Exceptions to the Act are sale of such drugs to agents of federal, state, or local government enforcement agencies for use in the course of their business or practice or in

the performance of their official duties.

The appellate court pointed out that even if the informer was an agent of the police, the Act made sale of a dangerous drug to the police lawful only when the drug was for use in performance of official duties. There was no evidence to that effect. Finding no error in the trial court's refusal of the instructions, the court said that the evidence was uncontroverted that the sole purpose of the sale of the drug was for consumption.

Pointing to the evidence that the physician sold more than 80 pills to the informer during a span of seven days, although the pill containers indicated the recommended dosage to be "1 tablet 2 times a day," the court said that it could reasonably be inferred that the pills were sold in bad faith. The court affirmed the trial court's conviction of the physician.—*LaDuron v. State of Indiana*, 299 N.E.2d 227 (Ind. Ct. of App., July 31, 1973).

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT — May 1975

Disease	May 1975	Apr. 1975	Mar. 1975	May 1974	May 1973
Animal Bites	1556	767	541	1019	1038
Chickenpox	634	501	565	668	715
Conjunctivitis	272	183	211	216	336
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	104	72	97	65	27
Gonorrhea	1863	841	765	910	796
Impetigo	166	104	101	122	112
Infectious Hepatitis	58	50	32	82	41
Infectious Mononucleosis	91	111	90	73	59
Influenza	2298	3317	4494	2561	1310
Measles					
Rubeola	80	88	70	41	100
Rubella	268	90	78	54	153
Meningococcal Meningitis	2	1	2	1	1
Meningitis, Other	6	8	4	2	1
Mumps	462	394	357	137	151
Pertussis (Whooping Cough)	6	4	5	4	1
Pneumonia	424	528	539	392	545
Poliomyelitis	0	0	0	0	0
Streptococcal Infection	1400	1509	1491	1595	1469
Syphilis					
Primary & Secondary	12	7	9	15	17
All Other Syphilis	115	80	91	103	84
Tinea Capitis	21	28	31	18	5
Tuberculosis (Active)	54	42	35	41	75

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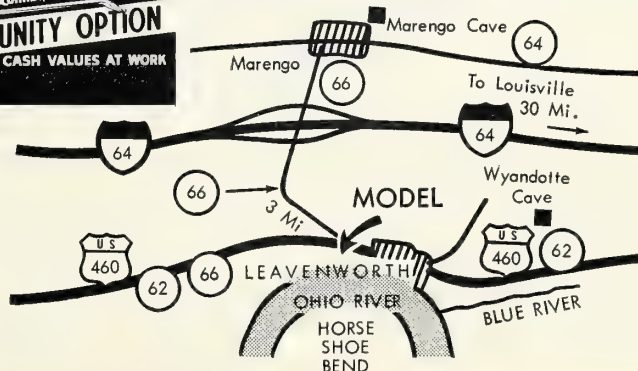
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The Woman's Auxiliary Reports to ISMA

Dear Doctors,

Since our reports are written so far in advance of publication, this is the first time that I have had an opportunity to thank your President, Dr. Wilhelmus, and our advisors, Drs. Sholty and Gattman, and all the other physician husbands who attended functions of our House of Delegates in Goshen. It is always encouraging to us to have your presence as well as the sharing of ideas and your support. Thank you.



A special thanks to Governor Otis R. Bowen, M.D., and the many officers, chairmen and physicians of the ISMA for the fantastic unity exhibited toward Indiana H.B. 1460 and the Senate amendment and final passing of the bill. You are to be congratulated for the fine leadership that you have exhibited in this medical liability field with the enactment of H.B. 1460, the Patients' Compensation Act.

Other states are following your example. At the recent Ohio State Medical Association meeting many physicians repeatedly said: "Thanks to your Indiana doctors for their fine leadership in this medical liability endeavor." I'm sure you are very much aware of recognition from other states with reference to Indiana in print and on television. Congratulations!

The magnitude of problems facing the AMA, ISMA, and Auxiliaries is depressing but can be a challenge for all of us. Dr. James Sammons, executive vice-president of AMA, touched upon some of the most pressing problems at a County Leadership Seminar in Chicago: Membership, Medical Legislation and its ramifications, the cost of malpractice insurance and lobbying for intelligent laws. Mrs. Norman H. Gardner, first vice-president, AMA Auxiliary, our keynote speaker at the House of Delegates, expounded on Bylaw changes, dues increase, and program implementation. President Wilhelmus updated us on the status of H.B. 1460. Dr. Sholty discussed your public relations program, Tel-Med.

I am looking forward to a challenging year as we work together to improve the image of medicine and to extend its goals. Please invite your wife, if she is not a member of the Indiana State Medical Auxiliary, to JOIN US—WE CAN DO MORE TOGETHER.

Sincerely,

A handwritten signature in cursive script that reads "Allie C. Reed".

Mrs. Edsel S. Reed
President
Indiana State Medical Auxiliary

Association News

EXECUTIVE COMMITTEE

Sat., March 8, 1975

The Executive Committee of the Indiana State Medical Association convened at 6:00 p.m., Sat., March 8, 1975, in the headquarters building, with the roll call showing the following present: Donald M. Kerr, chairman; William R. Clark, member; Vincent J. Santare, president-elect; Richard G. Ingram, chairman of the board; Hugh K. Thatcher, Jr., treasurer; Arvine G. Popplewell, assistant treasurer; Frank B. Ramsey, editor of THE JOURNAL; Jas. A. Waggener, executive secretary, and Kenneth W. Bush, administrative assistant. Gilbert M. Wilhelmus, president, absent.

MINUTES OF THE MEETINGS HELD JAN. 18 and JAN. 25 approved upon motion by Dr. Thatcher and a second by Dr. Santare.

MEMBERSHIP REPORT AS OF FEBRUARY 28, 1975, was reviewed and accepted by consent.

A STATEMENT FROM DR. WILLIAM R. CLARK for his expenses in attending the Leadership Conference was approved upon motion by Dr. Dukes and a second by Dr. Ingram.

TEL-MED. The committee requested a statement of costs and how long the existing funds would last and upon motion of Dr. Dukes and a second by Dr. Clark, the Association is to discuss with Blue Shield its recent proposal and to investigate other methods of financing. Upon motion of Dr. Ingram and a second by Dr. Popplewell, Dr. Popplewell is to investigate the possibility of some funding from the Regional Medical Program.

PROPOSAL FROM J. G. SULLIVAN ADVERTISING, INC. The secretary read a proposal from a J. G. Sullivan of South Bend outlining a proposal for commercial support of the Tel-Med program. No action was taken.

CHAMPUS MATTERS. The secretary read a telegram from the Department of Defense concerning the possibility that the CHAMPUS program will be placed under the same regulations as Medicare and that he had replied to the effect we would not agree to this and his reply was approved by consent. He was then requested to provide the committee with a complete cost breakdown of the CHAMPUS program.

THE TREASURER'S REPORT was discussed and, upon motion of Dr. Santare and a second by Dr. Dukes, the treasurer

MEMBERSHIP REPORT

	1975	1974	Increase (Decrease)
ISMA			
Full dues paying	3432	3508	(76)
Residents	33	64	(31)
Military	6		6
Exempt	497	512	(15)
Total	3968	4084	(116)
AMA			
Full dues paying	3035	3262	(227)
Residents	32	62	(30)
Exempt	503	512	(9)
Total	3570	3836	(266)
PAID ISMA—NOT AMA			
Full dues paying	397	246	151
Residents	1	2	(1)
	398	248	150

was instructed to sell the Johnston Mutual Fund shares and to reinvest the income in the best short-term vehicle. The remainder of the treasurer's report was approved by consent.

ORGANIZATION MATTERS

REQUEST OF PHYSICIANS SUPPORT AGENCY for use of mailing list was discussed and, upon motion of Dr. Ingram and a second by Dr. Santare, it was moved that the list not be supplied. Motion was defeated. Dr. Clark moved and Dr. Santare seconded the motion that the secretary obtain from the Physicians Support Agency copies of material they propose to send out to the mailing list of the Association. Motion carried.

LETTER FROM HEALTH SERVICES MANAGEMENT, INC., in which they ask that a representative be named to the Advisory Committee was referred to the president by consent.

LETTER FROM THE WOMAN'S AUXILIARY TO THE STUDENT AMERICAN MEDICAL ASSOCIATION requesting renewal of our membership at a cost of \$5.00 was approved upon motion of Dr. Dukes and taken by consent.

LETTER FROM THE INDIANA UNIVERSITY SCHOOL OF MEDICINE, DEPARTMENT OF NEUROLOGY, concerning the appropriateness of a physical therapist performing electromyography. Upon motion of Dr. Clark and a second by Dr. Dukes, the department is to be informed that it is the opinion of the Indiana State Medical Association that if a physical therapist performs this activity she should be under the direct supervision of a physician appropriately trained and, furthermore, that only such physician should make the diagnosis as a result of the test; that they be further

informed that the Indiana State Medical Association supports a resolution on this subject as adopted by the American Medical Association.

LETTER FROM LEGAL COUNSEL, STEWART IRWIN GILLIOM FULLER AND MEYER, announcing that their hourly rates would be increased by \$10.00 per hour effective January 1, was reviewed and, upon motion of Dr. Thatcher and a second by Dr. Dukes, it was voted to accept this communication but would object to the retroactive feature but would agree to the charge being effective as of the date of the communication. This was referred to the Board of Trustees.

LETTER FROM THE INDIANA PUBLIC HEALTH ASSOCIATION requesting a membership fee of \$100 was discussed and, upon motion of Dr. Santare and a second by Dr. Thatcher, it was approved providing that such a payment was made in previous years and if not, no contribution would be made. Motion carried.

A PREVIOUS REQUEST OF A DOCTOR QAZI for use of the mailing list to announce the opening of practice for plastic surgery and which was referred to the Marion County Medical Society for an opinion was brought to the attention of the committee. The opinion was reviewed and, upon motion of Dr. Santare and a second by Dr. Ingram to approve the request, was put to a vote and carried three to two.

LETTERS FROM THE WIVES OF TWO PHYSICIAN MEMBERS requesting a refund of dues, inasmuch as their husbands had passed away shortly after paying 1975 dues. By consent, the matter was referred to the respective trustees for discussion with the county society and if the county society agreed the refund then would be made.

A LETTER FROM THE AMERICAN MEDICAL ASSOCIATION LISTING VACANCIES on the Councils and Committees was reviewed and referred to the Board with the recommendation that it be left to the delegates.

A LETTER REQUESTING FINANCIAL ASSISTANCE FOR THE SAMA DELEGATES from Indiana University to attend their national meeting was reviewed and it was noted that their convention was already in progress and therefore no action was taken.

A LETTER FROM NATIONAL CAR RENTAL offering to provide members of Indiana State Medical Association with VIP cards was turned down by consent.

A LETTER FROM THE AMERICAN MEDICAL ASSOCIATION setting forth guidelines which have been developed for housestaff was tabled until the next meeting of the committee and in the meantime the secretary was instructed to supply copies to the committee members for their study.

A LETTER FROM MEDICINE CORPORATION seeking the approval of the Association for television programs on various areas of health was reviewed but no action was taken inasmuch as the material supplied was not sufficient for the committee to review the contents of the proposed programs.

A LETTER FROM AUTOGRAPHICS requesting Indiana State Medical Association to participate in their annual meeting with a gift of \$35 was approved upon motion of Dr. Thatcher and a second by Dr. Clark.

A LETTER FROM THE AMERICAN MEDICAL ASSOCIATION concerning the annual Sheen Award nomination was reviewed and, upon motion of Dr. Thatcher and a second by Dr. Santare, the name of Dr. J. O. Ritchey was to be submitted again.

A RESOLUTION ADOPTED BY THE THIRD DISTRICT MEDICAL SOCIETY was reviewed and taken as a matter of information.

A LETTER FROM THE MINNESOTA STATE MEDICAL ASSOCIATION announcing they were going to submit the name of Dr. George B. Martin as candidate for the Board of Trustees of the American Medical Association was taken as a matter of information.

THE SECRETARY DISTRIBUTED TO THE MEMBERS A REPORT OF THE ACTIONS taken at the recent meeting of the American Medical Association Board of Trustees.

THE JOURNAL. Dr. Ramsey stated he had no report to make.

MEDICAL DEFENSE. Payment of two claims (No. 318 and No. 323) for medical defense was approved upon motion of Dr. Santare and a second by Dr. Clark.

The committee had before it a claim (No. 322) for \$2775 for payment and, upon motion of Dr. Ingram and a second by Dr. Santare, the amount of \$2000 was authorized, the physician to be notified that was the maximum amount the available funds would permit.

An application for medical defense was received from a New Albany physician who had enclosed a copy of the complaint and, upon motion of Dr. Ingram and taken by consent, the secretary is to ask the physician to provide a copy of his attorney's brief on this suit.

FUTURE MEETINGS

National Health Forum, March 17-19, Lake Buena Vista, Florida. No representative will be sent.

Conference on Remote Emergency Medical Services, May 15-17, Lubbock, Texas. No representative will be sent.

Conference on Medical Malpractice, March 20-21, Arlington, Va. No representative will be sent.

Disabled Doctor Conference, April 11-12, San Francisco. No representative will be sent.

WASHINGTON TRIP. The secretary informed the committee he had taken the liberty of inviting Governor and Mrs. Bowen to our guests during the visitation and the Governor replied it would be impossible for him to attend this dinner and suggested that we invite his personal Washington representative, Mr. Don Newman. His recommendation was accepted.

The secretary informed the committee he had set up a conference with Dr. Roger Egeberg for 2:00 p.m., Tuesday, April 29, and had made arrangements for a briefing by the Washington office staff at 4:30 p.m.

By consent, it was agreed that Mr. Bush, Mr. Amick and Mr. Grindstaff would also attend this meeting.

AMA CLINICAL MEETING, HONOLULU. Mr. Waggener presented two proposals received from the AMA Travel Bureau concerning rates to be offered to the official family and the membership of the Association and it was approved to accept these two proposals.

NEW BUSINESS.

Upon motion of Doctor Thatcher and a second by Doctor Ingram, it was voted to refer to the Board of Trustees a suggestion that an appropriate memorial be adopted on behalf of the late Dr. Ken-

neth O. Neumann and that Mrs. Neumann be invited to the next meeting of the Board to receive the memorial.

There being no further business, the committee adjourned to meet again at the Hay-Adams Hotel in Washington, D.C., at 7:30 a.m., Wed., April 30.

BOARD OF TRUSTEES

Sun., Mar. 9, 1975

Dr. Richard Ingram, chairman of the Board, called the meeting to order at 9:00 a.m. in the headquarters office.

ROLL CALL

Dist.	Trustee	
1	Bernard B. Rosenblatt	Present
2	Paul W. Holtzman	Present
3	Eli Goodman	Present
4	Howard C. Jackson	Present
5	Cleon M. Schauwecker	Present
6	Paul M. Inlow	Present
7	John O. Butler	Present
7	Joseph F. Ferrara	Present
8	Richard G. Ingram	Present
9	William M. Sholty	Present
10	Martin J. O'Neill	Present
11	James A. Harshman	Present
12	Alvin J. Haley	Present
13	G. Beach Gattman	Present

Dist.	Alternate	
1	E. DeVerre Gourieux	Present
2	Edgar R. Cantwell	Absent
3	Thomas A. Neathamer	Present
4	William F. Blaisdell	Absent
5	William G. Bannon	Absent
6	Glen Ward Lee	Present
7	Donald C. McCallum	Present
7	John G. Pantzer	Present
8	Jack L. Alexander	Absent
9	Max N. Hoffman	Present
10	Leonard W. Neal	Absent
11	Lloyd L. Hill	Present
12	Franklin A. Bryan	Absent
13	Donald C. Chamberlain	Present

Officers/Executive Committee

Gilbert M. Wilhelmus	Absent
Vincent J. Santare	Present
Hugh K. Thatcher, Jr.	Present
Arvine G. Popplewell	Present
Frank B. Ramsey	Present
Joe Dukes	Present
John W. Beeler	Absent
William R. Cast	Absent
Donald M. Kerr	Present
William R. Clark	Present

Guests

Peter R. Petrich	Present
Charles A. Bonsett	Present
Jerry Neese	Present

Staff

Robert J. Amick	Present
Kenneth W. Bush	Present
Howard Grindstaff	Present
Bob Sullivan	Present
James A. Waggener	Present

Chairman Ingram: First of all, many of you got a *Sturgis Standard Code of Parliamentary Procedure* in the mail. We will deduct the price of each from your expenses here. Number two, our president will not be here today because of illness in his family.

MINUTES OF PREVIOUS MEETING

Chairman Ingram: I would now hear a motion concerning the meeting held Jan. 18 and 19, 1975.

Dr. Ferrara: I move the minutes be approved.

Chairman Ingram: We have a motion by Dr. Ferrara to accept the minutes and a second by Dr. Rosenblatt. All those in favor signify by saying aye. AYE. Opposed.

The minutes were approved.

Chairman Ingram: Now we will go to Item 4 and call on President-elect Santare.

REPORT OF PRESIDENT-ELECT

Dr. Santare: Thank you, Mr. Chairman. The Executive Committee did attend the Leadership Conference in Chicago. I think we did learn something. There were sections on PSRO. Present at the meeting were Representative Ullman, Oregon; Paul G. Rogers, who is the representative from Florida, and a gentleman from Texas. We were quite surprised that the AMA was getting along so well with people who we thought were not favorable to us.

The last thing I will announce is that the Lobby Committee has been eminently successful and I am sure that Dr. Muller called you. It seems to me he's on the phone about every other day, calling and giving progress on what has already happened. Our 1460 with some amendments has been voted out of the Labor and Economics Committee. It comes up for the third reading tomorrow. It seems to me that the attorneys all seem to vote against our bill, but the committee feels it will pass the House and go on to the Senate.

Dr. Goodman: I was wondering if we have information of what will happen in the Senate?

Chairman Ingram: It is felt that there would not be nearly the problem there was in the House, in that the sponsors have been selected and Gutman has promised to give it a fast hearing.

Dr. McCallum: Has our insurance committee looked ahead at what will happen if this bill does pass or have we considered setting up a mutual company? Obviously the testimony from the insurance company is that their structure won't change within the next five years, no matter what happens. I wondered if our insurance committee is still considering the possibility of our own company in light of the possibility that we have a maximum on the liability?

Chairman Ingram: Well, I am sure they considered that. The only problem is that they have been totally unable to find a carrier. We had a carrier about two years ago which was turned down by this group and since that time they have been unable to find a carrier that would deal with us. I think that's still the state of affairs unless someone here can correct me.

The Board then discussed extensively the current status of investigations with professional liability insurance carriers.

Chairman Ingram: We will now hear from Dr. Hugh Thatcher for the treasurer's report.

TREASURER'S REPORT

Dr. Thatcher reported in detail the current status of the Association's finances.

Dr. Thatcher: Concerning these Johnston Fund shares, the Executive Committee has acted as a financial committee to make these transactions and they did vote to sell these and then invest in short-term treasury bills. If there are objections from this Board, you can always overrule the Executive Committee. I will move that we support the actions taken by the Executive Committee.

Chairman Ingram: It has been moved and seconded that the Board support the actions of the Executive Committee. Is there discussion on the motion? Those in favor, signify by saying aye. The motion carries.

Dr. Thatcher: I move to accept the treasurer's report.

The motion was seconded and carried.

REPORT OF INDIANA MEDICAL MUSEUM

Chairman Ingram: I'm going to call on Dr. Charles A. Bonsett. He has a brief presentation concerning the Indiana Medical Museum which is being established at the old Central State Hospital. Dr. Bonsett: The Medical History Committee has been functioning now for approximately two years. During this period of time we have held two meetings per year and determine, primarily, in what way we can develop the Medical History Museum; and secondly, the wisest way to spend the amount of money that we have allotted to us. The primary purpose of my being here this morning is that sometime during the year 1976 our funds are going to be exhausted. It's our feeling that this should be entirely in the hands of the Indiana State Medical Association and that we should not go to other sources to direct it on a long term basis. I would like to answer any questions that any of you may have regarding what we are doing and, secondly, to make a request that one or more members of this group be directed to look into what we are doing personally and to report back to this group as to the advisability of long-term support by the Indiana State Medical Association for the continuity of this project.

Dr. Bonsett then explained the extent of activities of the museum.

Dr. Sholty: Back when this first came up, I volunteered to help with it and I am familiar with all the people associated with it down here so I'll volunteer. Chairman Ingram: All right, we have a volunteer for the Board Committee. Is there someone who would like to work with Dr. Sholty on this?

Dr. McCallum: I'd like to, also.

Dr. Haley also volunteered.

Chairman Ingram: Thank you very much, Dr. Bonsett. You have your committee. I'll take the liberty of appointing Dr. Sholty as the chairman. Mr. Waggener will now tell us about the changes in the CHAMPUS program.

REPORT OF THE CHAMPUS PROGRAM

Mr. Waggener: The CHAMPUS director has notified us of possible changes in the CHAMPUS program which would put us under the same regulations and under the same profiles the Blues are using for Medicare. Also, there are a few items which they will discontinue paying for. The main thing is that they have warned us that the government thinks we ought to put the CHAMPUS program on the same basis as Medicare. They asked that I reply to their telegram, which I did, and pointed out that there were several discrepancies in the concept. We have no way of implementing it because we don't know what the doctors' 75th percentile was, based on 1973 fees. OB, which is about 52% of the load, is not even covered by Medicare. I heard nothing more from them except I did talk to another person in the department at Denver and I understand at that time about 25 administrators said approximately the same thing.

Chairman Ingram: Are there any questions concerning this? Does this Board desire to make a statement in support of the CHAMPUS position, or not?

Dr. Santare: I will make a motion that this Board reaffirm Mr. Waggener's position.

Chairman Ingram: It's been moved by President-elect Santare and seconded by Dr. Schauwecker that this Board reaffirm Mr. Waggener's statement. Is there a discussion?

Dr. Goodman: I am in complete sympathy with this viewpoint but I'm wondering exactly what we are saying. Are we telling them to take this program away from us and give it to the Medicare intermediaries?

Chairman Ingram: I think that is not true at this point in time. Last night Mr. Waggener read to us the entire telegram and actually no action is intended to make these regulations apply to CHAMPUS. They are telling us they might be made. I think, quite frankly, they are testing us to see what we think of it.

The motion was then put to a vote and carried.

TRUSTEE REPORTS

Chairman Ingram: We will now have the reports of the trustees.

Dr. Rosenblatt: I have a remission of dues for an Evansville physician who is retired.

Motion was made, seconded and carried to remit the physician's dues.

Dr. Rosenblatt: I have three more things that need to be brought up at this time. I have two resolutions from the Vanderburgh County Medical Society which were submitted to me to present to the Board of Trustees here today. Should I read them?

Chairman Ingram: I would assume this is as good a time as any.

Dr. Rosenblatt: Whereas, financial stresses and fiscal restraints have been imposing restrictions and retrenchments upon programs of the Association, and whereas, physicians generally practice economy in their personal expenditures, including air travel, tourist rates, resident first-class rates; be it resolved that it is the policy of the Indiana State Medical Association that air travel costs incurred on business of the Association be reimbursed at tourist or economy rates, unless some physical ailment of the traveler makes it inadvisable for reasons of health or in cases of bona fide emergency trips when tourist accommodations are not available; and, be it further resolved that the Indiana Delegation to the American Medical Association be instructed to work for the adoption of a similar policy for travel costs by the American Medical Association. Approved by the directors of the Vanderburgh County Medical Association on March 5, 1975.

Chairman Ingram: Is it my understanding, Dr. Rosenblatt, that you're wishing the Board to submit it to the House this coming fall?

Dr. Rosenblatt: I think the Board should take some action on it now because we might have an economic upturn by that time and it wouldn't be appropriate.

Chairman Ingram: The Board can make a policy statement about these things. I believe this is correct, but resolutions as such, generating from county societies, normally do go to the House of Delegates for action by the House. Now, I'll stand corrected if somebody here wishes to disagree with that. Do I hear a motion concerning it so we can have a discussion?

Dr. Schauwecker: What's the present policy?

Chairman Ingram: Well, I was hoping someone would ask. So far as I know, and I'll stand corrected on this, whatever travel I have done has all been tourist class and I think that's generally the case. Now as far as the AMA delegates are concerned, they are paid a flat rate. They can go for that amount first

class, tourist class, or wind up paying out of their own pocket. In other words, they are allowed \$500 expense money per man for the AMA meeting. In no instance, unless the meeting were very close, would that allow for first-class accommodations and to live on for nearly a week.

Dr. Holtzman: What brought this to the attention of your society?

Dr. Rosenblatt: Well, because many of the men were traveling first class, and we felt that this comes from the society. I wasn't there at the time they made the resolution. It comes from the Board of Directors. There have been many of the officers and people who are employed by the AMA who have been traveling throughout the country first class, and that was something we didn't feel should be done since we had to have the \$60 assessment.

Dr. Ferrara: Is this really being directed to ISMA or AMA?

Dr. Rosenblatt: Both.

Dr. Thatcher: I move that this resolution be accepted for referral to the House of Delegates and referral to the AMA Delegation.

Dr. Goodman: I second the motion.

Dr. Holtzman: I move to amend the motion to refer to the House without recommendations.

Chairman Ingram: Is there a second to the amendment by Dr. Holtzman?

Dr. Jackson: I second.

Vote was taken on the amendment and it carried. Vote was taken on the motion as amended and it carried.

Dr. Rosenblatt: Second resolution: Whereas, the American Medical Association has been espousing fiscal restraint for some time; and whereas, drastic retrenchment of vital Association activities has recently been invoked; and whereas, significant and sustained economies could be quickly achieved with enhanced efficiency for the Association merely by holding most meetings in Chicago, where the headquarters and staff are already situated; be it resolved that until such times as the Association's resources permit the luxury of travel and transportation of staff and equipment, all meetings be held in Chicago, except for government-related activities which may be better served by a Washington location; be it further resolved that scheduled sessions at distant sites be rescheduled for Chicago unless compelling and persuasive reasons be advanced with appropriate fiscal data. Approved by the Board of Directors, Vanderburgh County Medical Association, March 5, 1975.

Chairman Ingram: Thank you. The Chair would hear a motion concerning this.

Dr. Jackson: I move that we refer this to the House of Delegates.

Dr. Schauwecker: Second.

The motion was voted upon and carried.

Dr. Rosenblatt: I have one more. This comes from the Vanderburgh County Medical Association. "Dear Dr. Rosenblatt: As you are aware, the Board of Directors of Vanderburgh County Medical Association is concerned about the liability assumed by the physician when he fills out and signs the medical report for automobile insurance such as the attached form. We have had communication with our legal counsel on the matter and I am also enclosing a copy of his response. The Board is uncertain what action might be taken to deal with the problem most effectively but believes that the Indiana State Medical Association might be aware of action which could be taken at the state level and which would be more useful than any effort which might be made locally. For this reason the Board voted to ask you to discuss the problem with the Indiana State Medical Association Board of Trustees and ask them for assistance in the matter." Now, this, as you all know, is that insurance companies, when people arrive at the age of 65, in order to renew their insurance for their automobiles, require an examination. They send this copy to the doctor and he is to fill out this report. Now, it doesn't say you have to examine the patient; all it asks is a group of questions which you answer yes or no. For instance, the last one says that as of the date of the last examination, is the applicant's general, physical and mental condition such as to impair his safe operation of an automobile? You don't know what kind of a driver this man is in the first place and how you can tell from the last examination whether he is able to operate an automobile if you haven't seen him for a year. Our attorney feels that if you answer yes and this man goes out and gets into an accident, you might partially be liable; and he also feels that if you answer no, and this man isn't given a license, he can sue you, personally, for keeping him from getting the license.

Chairman Ingram: I feel sure that we did deal with this problem at this Board very recently, but I can't remember details.

Dr. Holtzman: About six years ago this came before the insurance commission and was discussed by the Board at that time. It was decided that an answer to such a question would be "no opinion." I have been doing that myself and have never had any problem.

Dr. Ferrara: I think this is very apropos and may serve as protection for members of ISMA. I move that this be referred to our legal counsel with the remarks that were made by Dr. Rosenblatt and by Dr. Holtzman to see what they advise, so that we can advise our constituents.

Dr. Holtzman: Second.

The motion was put to a vote and failed.

Dr. McCallum: Motion might be better that we go on record as opposing this

statement in the application with the feeling that the doctor is not able to make this judgment and write a letter to the insurance company and send copies to all the doctors in the state to make them aware of what we are doing and also send a copy of the resolution to the State Insurance Commissioner.

Dr. Rosenblatt: I second it.

Chairman Ingram: I am told, and I had the feeling this was so, that there has been action on this in the past. We have a motion, but I wonder if we might hold this until the afternoon session and give Mr. Waggener time to research the past action. We have a motion to table made by Dr. Thatcher, seconded by Dr. Haley, in favor of tabling until this afternoon.

The motion to table until the afternoon session carried. The discussion on the matter then continued in the afternoon session as follows:

Chairman Ingram: I would like to recall Dr. Rosenblatt's business concerning the driver's license exam. I'm going to read what we have done about this and then you can take such action as you may deem as necessary. This was in 1968—68-20 Part A.

Dr. Ingram then read Resolution 68-20A. The next item is 68-20B which deals with the insurance company statement. It says, "Whereas, It is common practice of insurance companies to ask the physician to pass on his patient's ability to drive; and whereas, this places the physician in an awkward position with his patient and tends to place all the burden of responsibility on the physician; and, whereas, physicians are willing to submit data and do appropriate examinations, they believe questions of driving ability and insurability should rest with the insurance company instead of with the physician; now, therefore, be it resolved, that the officers, the Executive Committee, the Board of Trustees of the Indiana State Medical Association use the thought expressed by the above paragraphs in their deliberation of such questions and they they, and all other medical associations, committees or groups urge that insurance companies adopt this form particularly emphasizing the authorization for payment by insurance companies; and be it further resolved, that physicians would still retain the prerogative of choosing whether or not to do these examinations."

Chairman Ingram: This is what we have previously passed. It may be the sort of thing that we need to inform doctors and the insurance commissioner and insurance companies writing automobile insurance.

Dr. Gattman: I'd like to move that we reaffirm what the House of Delegates of 1968 passed, Resolution 20-B, and have this disseminated to all the county medical societies and to the Commissioner.

Dr. Goodman: I'll second.

The Board was then reminded of Dr. McCallum's earlier motion which had been tabled at the morning session.

Dr. McCallum: The original motion was to protest to the insurance company that we were not able as physicians to answer that question and also to circulate this letter among the members of the State Medical Association.

Dr. Santare: I move that we take from the table the motion proposed this morning by Dr. McCallum.

Seconded by Dr. Ferrara and the motion carried.

Dr. Gattman: I move that we accept my motion designated as an amendment to the original motion.

Dr. Schauwecker: Second.

Chairman Ingram: The motion made by Dr. Gattman is being offered as a substitute motion for the one by Dr. McCallum. It becomes an amendment by substitution.

Dr. Goodman: I have a further amendment.

Chairman Ingram: All right.

Dr. Goodman: That we request a reply from the insurance commissioner.

The motion to amend was seconded, put to a vote, and carried.

Chairman Ingram: We are now back to the original motion which was amended by substitution of a second amended motion.

Dr. Gattman's substitute motion as amended was put to a vote and carried.

Dr. Holtzman: The district meeting will be June 11 at the Elks Club in Vincennes. Dr. Goodman: Our annual district meeting will be Sept. 13 and 14 at Clarks-ville. This is a weekend meeting.

Dr. Schauwecker: The Fifth District meeting will be in the Holdiay Inn, Terre Haute, May 14. Golf will be at 11:30; business meeting at 4:00 p.m., women's entertainment at 4:00 p.m.; 5:30 p.m. social hour; and dinner at 7:00 p.m. Our speaker will be Temple Keith Spencer, Evansville, member of the ISMA Speakers Bureau.

Dr. Inlow: I want my alternate to make the announcement.

Dr. Lee: The meeting will be May 5, Richmond, and will be at the Forest Hills Country Club in afternoon and evening meetings.

Dr. Ferrara: The Seventh District meeting will be held May 14. The place has not been selected yet.

Chairman Ingram: Any other matters from the Seventh District?

Dr. McCallum: I was asked to bring up a problem that Marion County has had in regard to a profile and I think this was brought up at the last meeting. Since then most of the members of the Board applied for their profile and did receive it, but we didn't get much from them. It was ridiculous on some of the things that were presented. I understand that this was discussed at the Blue

Cross/Blue Shield meeting on Wednesday. We have tabled our motion from Marion County, but we are sincere about this and are considering withdrawing all support to Blue Shield, including getting out from under Resolution 26.

Chairman Ingram: Is there anyone who can bring Dr. McCallum up to date?

Dr. Dukes: Dr. Beeler is getting with the staff of Blue Shield to work things out and if it is not worked out, it will come back to us and we can take appropriate measures.

Chairman Ingram: Eighth District. I have no further report except that the meeting is at Portland.

Dr. Sholty: Ninth District. The meeting is going to be June 12 at the Curtis Creek Country Club. Rensselaer.

Dr. O'Neill: Two items I want to mention briefly here that were brought out at the Board of Directors' meeting of the Lake County Medical Society. Neither one of these demand any action, but I'm discharging my duties by mentioning these things. There was an objection by the directors of the medical society on the letter sent out from the Department of Public Welfare by Wayne Stanton, dated Feb. 10, 1975, pertaining to Medicaid reimbursement for non-therapeutic sterilization procedure. Everybody got that? I don't think that legally there is any action which can be taken on it. If anyone here feels that this could be rescinded, we will be happy to have a discussion on it.

Dr. Harshman: I suggest you refer that matter to Dr. Glock. As I understand it, he sits with the State Welfare Board as a member from Blue Shield. Does he not audit those meetings and have direct input into that Board?

Chairman Ingram: He has for years, I think.

Dr. Thatcher: This came out of a court decision. That's the reason we got caught on this sterilization matter because the regulations were sent out and then buried until the court decision was made in regard to a minor child. The decision was in the effect that you could not, because of mental deficiency, sterilize. This became such a "hot potato" that Wayne Stanton put that out for that purpose and that purpose only.

Dr. O'Neill: The other matter pertains to a problem in Lake County due to the present coroner, and I am sure this question has been discussed before. It would be possible that a resolution could come out of Lake County pertaining to the subject of the coroner system versus the medical examiner system. It pertains to the political atmosphere in the Lake County area. The coroner is a little harder to get along with than the last one was, and the real objection here is something that's difficult to live with; but on the other hand, the coroner is operating within the context of the law.

The purpose of my discussion here is that if a resolution would come up pertaining to this subject, it would necessitate a change in the Constitution in Indiana. As it is right now, we have a coroner system and it is a constitutional office. The coroner is elected, and he is an unqualified type of individual. So I think as a matter of discussion we are concerned whether or not it would be worthwhile to change the Constitution to replace the coroner system with the medical examiner plan.

Dr. Harshman: As you recall, this has been brought up on a general referendum and it was defeated because of the fact there were several offices that were included with the coroner and so the general public turned it down. Now there is House Joint Resolution 6, introduced this year in the Indiana General Assembly. It has been reported out on a do-pass and no action has been taken. So there is something in the General Assembly at the moment and the resolution amends the Constitution to remove the coroner as a constitutional office.

Dr. Santare: In order to amplify what Dr. O'Neill is talking about, it wouldn't merely be a question of changing the coroner; it would probably be a question of defining exactly what his duties are. He has taken a patient who has come from Illinois, transferred the patient from Hammond to Gary for an autopsy—a patient who I happened to see and a patient who had a carcinoma of the bowel that had invaded the uterus, obstructed both ureters. There was absolutely no question about what the cause of death was. He insisted on an autopsy. He is declaring people subject to autopsy. He has had so many autopsies done that the trustee can't pay for them. In addition, we are very much upset about the way he is treating the hospitals who are doing the bodies for the autopsy, and they won't do it any more.

Dr. McCallum: I would move that this Board go on record in support of HJR-6.

This was seconded by Dr. Schauwecker and passed.

Dr. Gattman: The 13th District meeting will be Sept. 10 at the South Bend Country Club.

Dr. Gattman requested remission of dues for a member of the Elkhart County Medical Society and the Board granted it.

REPORT ON I-MEDIC

Dr. Petrich: Our articles for incorporation for I-MEDIC are well along. The attorney had a few minor suggestions to make to us and they were acceptable to Mr. Waggener and myself. They really didn't change anything and we took the liberty to proceed rather than to wait for an additional meeting. Two weeks ago the representative from ROCOM with whom we have been dealing met with

the executive group at Winona Hospital and made a presentation to them to establish a pilot program. That hospital was chosen by ROCOM for several good reasons which will be explained to you. We provided ROCOM with a list of all the hospitals in the state of Indiana with a bed capacity between 200 and 400 and they chose Winona. People at Winona, with one exception, were very enthusiastic in their endorsement of the proposal.

Dr. Petrich explained that Winona had accepted to participate in the pilot program and then he introduced the representative from ROCOM, Mr. Jerry Neese, to explain the plan.

Dr. Petrich: The computer people and the administrative people at ROCOM and the Winona Hospital, in discussion we had down there, projected a six-month pilot program and our previous time was 90 days, so this Board will have to amend the previous time of 90 days.

Dr. Goodman: I move that we amend the previous motion to extend the pilot program from 90 to 180 days.

Chairman Ingram: There is a motion from Dr. Goodman and a second from Dr. Haley to extend the pilot program to 180 days. Is there discussion? Those in favor signify by saying aye.

The motion carried.

Dr. Goodman: I would like to address a question to Dr. Petrich in connection with the matter of I-MEDIC.

Chairman Ingram: All right.

Dr. Goodman: As I recall from a historical generation of this concept, following a mandate from the House to find a viable alternative to PSRO, I should like to hear from Dr. Petrich on the following: Are we still moving in the direction of a viable alternative?

Dr. Petrich: Absolutely. It will be an extremely viable alternative. OSMa through MAI has now dealt with the federal government and they have put up their solid wall front and said we're not going to set up small PSROs in our organization. We have a system, which is a complete system, endorsed by physicians and run by physicians; and if you want any reviewing, this is where the review process is. This is where it's always going to be in Ohio and they now have the endorsement of HEW for their system throughout the state of Ohio.

REPORT OF EXECUTIVE COMMITTEE

Dr. Kerr: Number one item is Tel-Med. We have 250,264 tapes played since the beginning, but we have no additional funding. We were wondering if Dr. Sholty's committee had any further information about that.

Dr. Sholty: No, we have tried every place we can think of.

Dr. Kerr: What happened to the Blue Shield money that was supposed to be coming? Anybody know about that?

Dr. Sholty: Mr. Waggener knows all about that.

Mr. Waggener: They have not been billed.

Dr. Kerr: Mr. Waggener had brought up some other things that we at least considered as part of the way to pay for the expenses of this. He had a letter from a man who is in charge of an advertising agency and it was his proposal that we could perhaps get financial support from other than the Blues on some of these tapes. For example, he made reference to the use of bank advertising presented by the ISMA and the bank. Another suggestion was to reduce the WATS lines. One other was the matter of RMP funds. There are still some RMP funds not committed. We will proceed to try to get some of those.

The next item was a matter from the I. U. Medical School regarding physical therapists performing electromyography. The school did not feel this to be a particularly appropriate action when done by the therapists themselves. We responded that we felt it should always be under the direct supervision of a qualified physician and, too, the interpretation of the test should always be by a qualified physician.

We had requests from the estates of two physicians, both of whom have died within the last month and a half. The requests are for the return of their dues. By action of the House some years back, it was decided that these requests had to also come through the county society. We bring it to your attention in the event this should occur in other districts, and we would ask Dr. Harshman if he will follow through with the physician from his district. Dr. Sholty, would you take care of this in your district? We also thought it appropriate that the Board draw up some kind of appropriate memorial for Dr. Neumann. As we all know, not only did he serve through all the chairs of the organization, but following his presidency, he remained very active until his death. It was thought that this would be appropriate and that we should invite Mrs. Neumann to the next Board meeting to receive that from the Board. This, of course, brings up the question of establishing precedent which we should perhaps do from here on—all widows of past presidents being so recognized and their husband's services recognized.

Chairman Ingram: Is there a motion relative to the matter just brought up? Dr. Sholty: So move.

Chairman Ingram: All right, it has been seconded by Dr. Inlow. Do we have discussion on the motion?

Dr. Goodman: I wonder if it might not be just a little more appropriate to do this at the succeeding annual meeting of the House of Delegates rather than the next meeting of the Board. I think it

would be a little more impressive, a little more people involved, and more appropriate. I will offer an amendment that this procedure be carried out at the next succeeding meeting of the House of Delegates.

Chairman Ingram: An amendment to the motion is offered by Dr. Goodman that such a recognition of services rendered by deceased past presidents be presented to their widows at the next succeeding House of Delegates' meeting. Is there a second to the amendment?

Dr. Gattman: Second.

The amendment was voted on and carried. Vote was then taken on the main motion as amended and it carried.

Chairman Ingram: We have one little matter of mechanics. Shall we delegate this to a given individual?

Dr. Santare: I move that the trustee from the district of the deceased past president prepare the memorial resolution.

Dr. Schauwecker: Second.

The motion was put to a vote and carried.

Mr. Waggener: Are these to be prepared and framed for presentation? If so, we ought to set a time limit on when the material should reach this office.

Dr. Goodman: I would think this calls for no action and certainly should be handled on a case-by-case basis.

Chairman Ingram: On a case-by-case basis. All right. Could we not direct our executive secretary or one of his people at his direction to get with the trustee of the districts involved and carry this out between now and October?

Dr. Harshman: Is this going to be for those deceased during the year or are we going to go all the way back?

Chairman Ingram: Starting now.

Dr. Kerr: You all received notice that there are some openings on committees and councils of the AMA. We were asked to supply names for possible candidates. In our discussion last night, names were mentioned as possible candidates, Dr. Wood for one; and Dr. Egger is interested in getting on the Continuing Medical Education Council. I bring this to you for further consideration. We had hoped to have consultation with the AMA delegates, but they were not here. They have to be in by March 15.

Chairman Ingram: The idea in the discussion in the Executive Committee, I think, is important and that is that this would be in consultation with the delegation. They understand the politics and have a candidate for a slot at this coming meeting. I would suggest they be consulted unless you desire otherwise. In other words, use the wisdom of the AMA delegation in submitting such names. Do you have anything to say, Dr. Harshman?

Dr. Harshman: We have talked about

this as a delegation in Portland and went over it very extensively. The nomination of Dr. Egger was talked about in his presence and he agreed it would not be advisable to submit his name for the Council of Medical Education at this time since there was not a slot available that we could foresee success in. Concerning the Judicial Council, I might tell you how the president of the American Medical Association each year names his selection to the Judiciary Council. The House has but one action. They cannot nominate a man in lieu of the president's nominee so that is the manner in which that slot is filled. Now, if the president of the AMA nominates Dr. Wood, I am sure we'll be very happy to support that nomination. I think that as a Board or as a state society, if a letter is written to Dr. Todd stating we wish his name to be considered, I am sure Dr. Todd would receive it in the light in which it is given.

Dr. Ferrara: I move that the Board support Dr. Wood as replacement on the Judiciary Council.

Dr. Goodman: I second the motion.

Chairman Ingram: All right, now do you mean in the sense that Dr. Harshman described in writing a letter?

Dr. Goodman: Yes.

The motion was put to a vote and carried.

REPORT ON PATIENTS' COMPENSATION ACT

Chairman Ingram: I would like to call on Dr. Muller to give a brief report on the status of our Patients' Compensation Act in the legislature.

Dr. Muller then reported in detail on the activities of the lobbyists and of the committee.

DISCUSSION OF UTILIZATION REVIEW

Chairman Ingram: We have under Item II the business of utilization review. We have brought some background material. I'd like to give you what other people have done in this area and then see if this Board wishes to generate any sort of a statement. The Texas Medical Association did adopt a statement. The policy states, "It shall be policy of TMA that expenses of conducting a utilization review program shall be borne by company or agency which required the review. Physicians who work regularly in a utilization review capacity shall be appropriately compensated for their services. Nonphysicians or professionals who work in a review capacity will be responsible to and shall be directed by the physicians. TMA feels that it will best serve interest of public, patients, and medical profession if physicians will lend experience and their expertise to development and management of the systems designed in which the medical statistical data will be fed. TMA recognizes that utilization review is an institution-based

activity in which law and regulations require that certain conditions must be met before reimbursements may be made and that the responsibility for the meeting of requirements rests with the individual hospital using their own facility."

We also have a resolution unanimously passed by the Tippecanoe County Medical Society, Feb. 11, 1975. "Whereas, physicians are under increasing pressure from patients and relatives for hospitalization for investigation and treatment and to deny such requests places the physicians in an untenable position; and whereas, physicians are under increasing pressure from fiscal intermediaries and government agencies to determine necessity for hospitalization and to limit hospital stay; and whereas, recent legislation indicates the trend to immediate review of hospitalization to determine necessity and possibly making the physician financially responsible for hospital cost if admission is determined; now, therefore be it resolved, that we, the physicians of Tippecanoe County, request the fiscal intermediary to place a paid representative in each hospital whose function it shall be to determine the necessity of hospitalization by interviewing the patient and relatives and affixing the stamp of acceptance or rejection on the chart of each patient prior to admission." Resolution unanimously passed by the Tippecanoe County Medical Society.

As you will recall, you were invited to attend a special meeting of the Third District of ISMA on Jan. 19, 1975. The purpose was to see if the Third District could agree on a common course of action to take back to our hospital medical staffs concerning working under PSRO. A motion from the medical staff executive committee of Floyd County Hospital, New Albany, was adopted without a dissenting vote. The resolution stated that the physicians of the Third Medical District will do nothing toward implementation of the PSRO law. HEW will have to provide the reviewing officers for the required daily reviews; provide the nurse coordinators and the funds and the expense to make it work in each hospital. This position is entirely our prerogative as given to us as the law is written. Any admission or increased length of hospital stay not acceptable to the PSRO will then not have recourse to sue the attending physician because the PSRO office will be responsible for unnecessary hospital admissions.

This is a statement by Malcolm C. Todd, M.D., president of the AMA: "We are here today to announce the filing of a lawsuit against the new hospital utilization review regulations being imposed against the American people by the U.S. Department of Health, Education and Welfare. At the moment these regula-

tions apply only to Medicare and Medicaid patients, but HEW and many hospitals expect to apply them to all patients. Therefore, we have been joined in our suit by two patients who receive benefits under Medicare, two patients who receive benefits under Medicaid, and two patients who are covered by no government program. And we have been joined by each of their doctors. This is the first time we of the American Medical Association have taken legal action against HEW. It may not be the last. We serve notice now that we will oppose every attempt by the government to interfere between a patient and his or her physician."

Dr. Ingram then continued with the entire report from the AMA president.

Dr. Ferrara: I move that this Board support everything Dr. Todd said in his statement.

Dr. Schauwecker: I second that and I would like to include a strong amendment to the effect that if it requires an assessment of each member of the ISMA, the Board move to implement this—the Board goes on record of being in favor of such—that we feel very strongly about this.

Dr. Goodman: I'll second the amendment.

Chairman Ingram: All right, now has everyone heard the motion to amend made by Dr. Schauwecker? It says we feel so strongly about this that, should it be necessary in the preparation of defense of this suit, we support an assessment of members of ISMA. Is that seconded by you, Dr. Goodman?

Dr. Goodman: Yes, but I'd like to offer an additional amendment that this Board at this point in time urge the entire membership of the Indiana State Medical Association pay the American Medical Association dues including the additional \$60 assessment and that we are willing to be subject for further assessment.

Chairman Ingram: Now that really amounts to a total rewording . . .

Dr. Goodman: But I'm offering it as a substitute amendment.

Chairman Ingram: Do you, Dr. Schauwecker, accept that? Now we have a substitute amendment offered by Dr. Goodman.

The motion was seconded.

Chairman Ingram: The vote now is immediately on the amendment offered by Dr. Schauwecker editorialized by Dr. Goodman and seconded by Dr. Goodman. All those in favor of the amendment signify by saying aye.

The amendment was adopted.

Chairman Ingram: Now we are dealing with the original motion as amended. The original motion is that we support Dr. Todd's statement and then amend it with these additional amendments.

The original motion was voted on and passed.

Dr. Ferrara: Mr. Chairman, I would

like to move that this Board consider sending this particular information to all of the medical societies, immediately, and also a copy of our action to Malcolm Todd and the AMA.

Dr. Schauwecker: I second that.

A vote was taken on the motion, following discussion, and it passed.

Chairman Ingram: We have two items now for mailing so it might be the sort of thing we might incorporate; that is, a regular mailing which will go out in the next 10 days or so. There is no reason that in that mailing we could not include both of these issues.

Dr. Harshman: In order to generate some discussion legally, I would move that this Board adopt the statement from the Texas Medical Association.

Dr. Schauwecker: I'll second it.

Dr. Ingram then repeated the statement of the Texas Medical Association. There followed extensive discussion of the statement and PSRO.

Dr. Ferrara: I move we table the motion until the next meeting.

Dr. Schauwecker: The motion to table was put to a vote and passed.

Dr. Goodman: Mr. Chairman, I wish to make a new motion which I trust is not in conflict with the action. In light of our endorsement of Dr. Todd's statement and the implied endorsement of the court action, we should ask all concerned (the AMA, HEW) for the deferral of additional implementation of the utilization review procedure.

Chairman Ingram: The Chair would rule that this is not in conflict.

The motion was seconded by many.

Dr. Santare: As I understand your motion, fine, address it to the federal government, but why send it to the AMA and everyone else? Because as we said before, utilization review could be included in PSRO and you would be asking people who already started on the particular line of action to stop where they are. I think I-MEDIC is actually utilization review. I think your motion is so broad and extended to so many areas that we may be defeating our own purpose.

Dr. Goodman: I would editorially be willing to withdraw everything except HEW. This editorial change was agreed to by the second, Dr. Schauwecker.

Dr. Thatcher: You've got the wrong groups because this utilization review demand came out of Social Security Administration and did not come out of HEW. It preempted HEW so I would ask you to editorially change that to Social Security regulations.

". . . and other concerned federal agencies" was also added to the mailing of the statement of deferred action.

Dr. Goodman: I would accept that editorially.

The second agreed. The motion was then put to a vote and carried.

Dr. Goodman: Could we clarify that we have now recommended a policy to the hospitals in the state of Indiana which is that everything stands where it is and could we now include this information in the sheet we're going to send out pretty soon? I would like to advise our constituents of this action.

Chairman Ingram: That will be a part of the proceedings of this meeting that are mailed to every county medical society within 10 days.

REPORT OF THE COMMISSION ON INTERPROFESSIONAL RELATIONS

Chairman Ingram: Next, report of the Commission on Interprofessional Relations. In their report they recommend that the Board consider forming a seven-man group to meet with seven attorneys to have an interprofessional relations contact. In supporting information, Dr. John Beeler called me personally and then sent the letter which I'll read.

"Dear Dick, just a note to re-enforce my telephone conversation with you today concerning my answer to the Interprofessional Relations Commission report. I believe that the Medical-Legal Committee should be enlarged from the current three members to seven members. This would bring us equal representation to the current membership of attorneys on the legal side of this committee. In addition, I believe that the change in the bylaws two years ago as to the purpose of this committee would make the Medical-Legal Committee the logical standing committee to handle these types of problems. I would appreciate your presenting these recommendations to the Board for me."

Dr. Santare: I move that we recommend that the Medical-Legal Review Committee have at least three members from each organization.

Dr. Goodman: I'll second your motion.

Dr. Santare: And that we suggest to the House that we change the bylaws wherein the Medical-Legal Committee should consist of at least three members—in the form of a resolution and then referred to the Commission on Constitution and Bylaws.

Chairman Ingram: I believe that the Board can recommend that to the Commission on Constitution and Bylaws. They could put it in their report; it could lay on the table overnight and be accomplished at the end of the next session of the House of Delegates, if that is their desire.

After considerable discussion, the motion was put to a vote and carried.

REPORT ON PUBLIC LAW 93-641

Chairman Ingram: We will now discuss Public Law 93-641 which has to do with the establishment of health service areas. This was mailed, I think, to everyone. We have been requested by Dr. Paynter to submit suggestions for areas, area designations, and also that we make our

objections known, whatever they are. The AMA is threatening to file suit upon this as well to delay its implementation. They have not done this, however, because they are waiting, I understand, the outcome of their present suit. They think this might detract from it. I have taken the liberty of asking Mr. Waggener to give us a little background information on the present area of health area designations in the state.

Mr. Waggener then explained the area designations and stated, "You notice that the material which was sent to you calls for a minimum of 500,000 people in that area. It also provides that you can have an area of less, not more, less than 200,000. The Governor may even petition for an area of less than 200,000. I would suggest you consider writing to the Governor and ask him to designate the 14 health areas for this particular purpose. I would point out to you that none of these cross state lines."

Dr. Goodman: I move that we support Mr. Waggener's program and tell the Governor we'd like to have his support.
Dr. Jackson: I second.

The Board then discussed at length the regional selection, distribution of federal funds, and other pertinent material.

Dr. Goodman: I have to agree with Dr. Popplewell in the light of the discussion that has been held. I think we do have to leave our options open to other designations within the state.

Chairman Ingram: Are you proposing an amendment to your motion?

Dr. Goodman: I think perhaps we ought to change it around a little to say that it be the 14 presently designated areas, or combinations thereof, and in any event not outside the state of Indiana.

Chairman Ingram: Now we have essentially a new motion.

Dr. Butler: I think we would be relatively safe with what Dr. Goodman has said because, administratively, if this thing ever crosses the state line a lot of the game is going to be lost. I think, more important than the ties of the district, is the fact that they all remain in Indiana.

Chairman Ingram: The motion is then to combine existing areas but in no event cross the state line.

The motion was put to a vote and carried.

Dr. Ferrara: Would it be apropos at this time, in the light of the fact that we concur with AMA's fight in the courts, to voice an opposition to Public Law 93-641?

Dr. Goodman: Mr. Chairman, I think our reply will go to Dr. Paynter and I would see nothing wrong with indicating in that letter that we are basically opposed to this sort of thing. In the previous minutes on page 9a it states that the AMA will go to court and attempt to prohibit the federal government

from implementing the National Health Planning and Resources Development Act and the motion was made that this Board send a communication of commendation. This was seconded and voted upon.

Chairman Ingram: Do you want to submit a motion?

Dr. Goodman: I move that we send Dr. Paynter and the Governor both copies of the commendation of AMA, opposing the law.

The motion was seconded, put to a vote, and carried.

Dr. Popplewell: As a follow-through on this, I've been appointed by Marion County as being their representative to push for something that's going to work satisfactorily for Marion County because everyone else is trying to run the doctors' and hospitals' business except the hospital and the doctor, and this law is going to provide for that more than any other law that was ever passed. I think we need a mechanism where in the interim we have the ability to communicate so we can work conjointly on things. We're going to tell them what we believe. We are not going to have a prayer if we don't provide some mechanism. Somebody needs to decide in this state which of these areas we already can logically work together.

Chairman Ingram: Is there further action on this?

Dr. Goodman: Mr. Chairman, I move that this Board appoint a subcommittee to work in the matter as outlined by Dr. Popplewell.

Dr. Butler: Second.

A vote was taken on the motion and carried.

Chairman Ingram: What I would love to have is three volunteers.

Drs. Harshman, Goodman, and Popplewell volunteered for the committee. Dr. Popplewell was named chairman.

REPORT ON CONSTITUTION AND BYLAWS RECODIFICATION

Chairman Ingram: We're down to new business. I have two notes. I would like to mention the first one. I have studied things recently concerning our state organization. I found a morass of conflict in our Constitution and Bylaws and a total absence of any reasonable explanation of the duties of some officers, and so on, and also direct conflict between the duties assigned to one officer and to another officer. I put this on the agenda to generate a little discussion, or none, or whatever you wish, on the possibility of talking with the Commission on Constitution and Bylaws about recodification.

I have also a communication to the Board of Trustees from the Commission on Constitution and Bylaws that says at the meeting of the Commission held Sunday, March 2, it was determined that the Constitution and Bylaws of ISMA need-

ed recodifying and streamlining; therefore, the Commission respectfully requests the Board to authorize it to have a recodification of our Constitution and Bylaws. You will recall at the last meeting when we referred to the report of the Committee on Future Planning, this would entail massive changes in our structure. We are developing that.

Dr. Thatcher: I think this is all too true and I think you're wise to take the helm. I think the Board should, and I will so move, that the Board authorize them to attempt this recodification.

There were many seconds.

Dr. Lee: I was at this meeting of the Commission on Constitution and Bylaws and we asked legal counsel how big a job this would be and he said he could have it prepared, and it would not be an extensive job, so it can be presented to the House of Delegates.

Chairman Ingram: Now, you would expect this to come back through this group. Would you not choose to study it before it went to the House. I would presume that would be so. The intent of the resolution is to demand this by the next meeting of the House. Is that right, Dr. Thatcher?

Dr. Thatcher: Yes.

The motion was put to a vote and carried.

REPORT ON COMMISSION ON MEDICAL ECONOMICS AND INSURANCE

Chairman Ingram: We will now hear from Mr. Waggener.

Mr. Waggener: Dr. Neumann asked some time ago that I bring this to the Board for a decision. It's made to you by him without a particular recommendation. You may remember a couple of years ago we were quite enthusiastic about the concept of setting up a corporation to sell malpractice insurance or be broker. The commission has also been working with Mr. Townsend and Continental on the same concept. We're trying to get a little income back into the Association from their activities. Mr. Townsend has made an offer that they would pay the Association \$5.00 per policy written on any member of the Association. Dr. Neumann requested that you decide whether or not you're going to accept this. This refers to all of the policies.

Dr. Harshman: In order to get the discussion on the floor, I would move we accept the proposal.

Dr. O'Neill: Second.

Pros and cons of the matter were then discussed extensively.

Dr. Holtzman: I am opposed to it violently. We're not in the insurance business. This makes us a partner in crime, such as so-called fee-splitting and everything we're opposed to. I am violently opposed to this.

Dr. Harshman: We've sat around this

table on more than one occasion discussing alternative ways to finance the Association. The basic thrust of the malpractice insurance plan was that we would set up a subsidiary corporation and we would share in the broker's fee and we accepted that. Other state societies do the same; that's not saying it's right or it's wrong. I think we're in a financial bind and I hope I'm not selling my soul for \$5.00, but I'm trying to think in my own mind why we shouldn't and I can't think of a single reason why we shouldn't.

Dr. Ferrara: Mr. Chairman, how much money is involved? Would it be \$50 or \$100?

Chairman Ingram: I have no idea; Mr. Waggener has no idea, so I don't know what to tell you.

Dr. Ferrara: Well, then I will move to table this to the next meeting and see if we can have any idea as to how much income is forthcoming.

Dr. Schauwecker: I second that.

A vote was taken on the motion to table and was defeated by a 7 to 6 count. Following additional discussion, a vote was taken on the motion to accept this and it carried.

REPORT ON TEL-MED

Dr. Sholty: I have done everything I can think of and I am wondering if the Board would approve of a letter from the Board to the doctors in this state asking for volunteer contributions to keep it going at least until the House of Delegates meeting, because this by far is the best public relations program we have ever had.

Dr. Ingram: We have no motion yet. Is there discussion on this or is there a motion forthcoming?

Additional discussion followed.

Dr. Santare: I move we continue the Tel-Med program until our next Board meeting; and meanwhile, our special committee meet with Dr. Black and Mr. Waggener and the responsible people and determine the most economical way of running the program and means of financing.

Dr. Goodman: I'll second that.

The motion was put to a vote and carried.

Dr. Sholty: Just to get an opinion, I move that the executive secretary be authorized to write a letter to the doctors in the state of Indiana stating our situation and asking for any volunteer contributions.

Chairman Ingram: Seconded by Dr. Jackson.

Dr. Harshman: I don't believe the executive secretary should be put in the position to ask for donations from our colleagues. I think it should go out under the name of the president, or chairman of the Board.

Dr. Goodman: I would like to move that the motion now under consideration be

tabled until next month when we will have more information.

Dr. Schauwecker: Second.

The motion to table carried.

REPORT ON THE CONVENTION

Dr. Chamberlain: As a point of information, the Indiana Chapter of the American College of Radiology held its meeting today and decided not to meet at French Lick because they do not want to go to French Lick. There was no publication on what to do at French Lick. I would hope that this information be noted because there are other groups planning not to attend. I think this would be a disaster for our meeting. We hope that something would be done to get these people at our annual meeting.

Dr. Chamberlain discussed his concern further.

Dr. Santare: The problem is that Tuesday has been scheduled for sports and medicine and the specialties are all being thrown in on Wednesday when you have the House of Delegates meeting. Ob-Gyn has already voted not to come down. Medicine was quite upset about the whole thing. I conveyed this to Dr. Wilhelmus and I was hoping he would be here this weekend.

Chairman Ingram: Would you, Dr. Chamberlain, convey also your message to Dr. Wilhelmus because, really, it's his program.

REPORT ON JOINT COMMISSION ON ACCREDITATION

Dr. Holtzman: I would move that a letter be directed to Dr. Sprague Gardiner and jointly sent to the Board of Commissioners of JCAH objecting to an arbitrary mandate the Board established in August 1974. Specifically, this mandate has a prerequisite for accreditation which rules that after July 1976, hospitals must demonstrate that they are completing one outcome audit per month per major service. Conceivably in a 300-bed hospital this would amount to 60 audits per year in the hospital if it has its services, medical surgical, pediatrics. This letter should object strongly to this mandate stating the audits are in excess of good judgment and would disallow prudent investigation. It is also time-consuming for busy physicians to the point of sacrificing audits for good patient care. We would ask the JCAH for their reasons for establishing this mandate and would explore their redecision on this mandate. The motion was seconded, put to a vote, and carried.

REPORT ON AD HOC PROFESSIONAL LIABILITY COMMITTEE

Dr. Haley: I move that you, the chairman, appoint an evaluation committee to meet with the Ad Hoc Malpractice Committee shortly after the termination of the legislature. The purpose of this committee should be to find out the things

which the committee did, the things which the committee has done, and the things they wished they had not done. I feel that this would be helpful as a report to the House of Delegates. I think it might be helpful in a decade or so when our successors have similar problems and they want to know how we did that back in 1975.

Dr. Butler: Second.

Dr. Goodman: I understand fully the desire expressed here, but I would like to say that I think the people that have been doing this have had such zeal, I anticipate surely they will report to this Board as a whole.

Chairman Ingram: Would there be any reason not to have this existing group here when this is over and make the committee report and have questions asked of them by this Board?

Dr. Haley: That would be fine.

The motion was then put to a vote and carried.

Chairman Ingram: I will so designate that they will be invited to the Board and so ask the Board members to prepare questions which you have in mind. We'll use the transcript as the document you desire.

REPORT ON INDIANA UNIVERSITY FINANCES

Dr. Butler: Dr. Irwin and Dr. Beering appeared before Marion County this week to outline their plight with the budget. They lost about four-and-a-half-million dollars with federal and state funds. I wonder if it would be proper for our people in the legislature to get with them and try to help their cause. I move, Mr. Chairman, that our legislative representatives contact these people at the University and help them in any way they can in obtaining the funds they need to continue the operation as it now exists.

Motion was seconded.

Dr. Jackson: I'd like to amend the motion by saying that if we are successful in restoring any money to the University, we point out to the dean and faculty the success of our efforts.

The amendment was seconded. The amendment was put to a vote and carried. Vote was then taken on the amended motion and it carried.

FUTURE BOARD MEETINGS

May 4 was then decided upon as the date for the next Board meeting. Chairman Ingram said May 3 also might be utilized, depending upon the extent of the agenda.

June 8 was set for the June meeting of the Board.

ADJOURNMENT

The meeting was adjourned at 4:00 p.m.

EXECUTIVE COMMITTEE

Wed., Apr. 30, 1975

The Executive Committee of the Indiana State Medical Association met in the Executive Suite of the Hay-Adams Hotel, Washington, D.C., at 7:30 a.m., Wed., Apr. 30, 1975. The roll call showed the following present: Donald M. Kerr, chairman; William R. Clark, member; Gilbert M. Wilhelmus, president; Vincent J. Santare, president-elect; Richard G. Ingram, chairman of the board; Joe Dukes, immediate past president; Hugh K. Thatcher, Jr., treasurer; Arvine G. Poppewell, assistant treasurer; James A. Waggener, executive secretary and Kenneth W. Bush, administrative assistant.

MINUTES OF THE MEETING HELD MAR. 8, 1975, were approved upon motion of Dr. Thatcher and a second by Dr. Ingram.

MEMBERSHIP REPORT AS OF MAR. 31, 1975, was reviewed and Dr. Clark requested the names of the members of the Allen County Medical Society who has paid state dues but not AMA dues.

OFFICE BREAK-IN. The secretary reported on the recent break-in of the headquarters building and the theft of a typewriter, and pointed out this is the second break-in which has not been caught by the present alarm system. He presented a proposal from American Alarm Company, Inc., and he was instructed to investigate other alarm systems and report to the Executive Committee at its next meeting.

TEL-MED. The secretary also reported that he had not received a contribution toward the operation of Tel-Med from Blue Shield as yet and he had directed a letter to Regional Medical Program requesting additional funding of \$65,000 to run the program through Dec. 31, 1975.

CHAMPUS CONTRACT was presented for signature of President Wilhelmus and it was approved upon motion of Dr. Thatcher and a second by Dr. Clark.

TREASURER'S REPORT. The treasurer gave an abbreviated report and recommended that the proceeds from the cashing in of the Johnston Mutual Funds be placed in the General Fund to help offset the deficit created in the budget on H.B. 1460. The motion to approve the treasurer's report and recommendation was approved by consent.

ORGANIZATION MATTERS

REQUEST OF AMA DELEGATION. The secretary read a letter from Dr. James A. Harshman forwarding a request from the ISMA delegation to the American Medical Association in which they requested credit cards be procured for calling other delegates throughout the country. Following discussion of this

point, upon motion of Dr. Ingram and a second by Dr. Santare this was referred to the Board of Trustees.

REQUEST FOR MAILING LIST by David A. Josephson, M.D., Indianapolis. If this physician is a member of the Association and approved by the Marion County Medical Society, the list will be furnished him. This was approved upon motion of President Wilhelmus and a second by Dr. Ingram.

REQUEST OF METHODIST HOSPITAL for self-adhesive labels for use for J. O. Ritchey Day was approved on motion of President Wilhelmus and a second by Dr. Clark.

A LETTER FROM JAMES E. BOTKIN, M.D., concerning the refund of dues of the late Fred E. Dunbar, M.D., of Marion, who expired April 4. This matter is to be referred to the district trustee for an official opinion of the county medical society and this action was taken upon motion of Dr. Thatcher and a second by Dr. Dukes.

TWO LETTERS FROM THE OFFICE OF THE GOVERNOR transmitting the requests of two physicians seeking appointment on the Malpractice Study Committee created by the passage of H.B. 1460 were taken as a matter of information.

LETTER FROM FRED W. DIERDORF, M.D., was read to the committee and the contents taken as a matter of information.

THE MINUTES OF THE COMMISSION ON VOLUNTARY HEALTH AGENCIES in which they made a recommendation that the ISMA contribute \$25 toward the support of the Interagency Council on Smoking and Health was approved upon motion of Dr. Thatcher and a second by Dr. Clark.

A REPORT FROM THE CONVENTION ARRANGEMENTS COMMISSION in which they suggested that junior medical students be taken to the annual meeting at French Lick on Tuesday, Oct. 21, in which they reported they had the approval of Dean Beering and the Eli Lilly and Company would furnish two busses at no charge for transportation of these students but the luncheon would have to be underwritten by the ISMA. Following discussion of this, the recommendation of the Commission was approved on the motion of Dr. Ingram and a second by Dr. Thatcher.

THE SECRETARY READ A LETTER FROM THE AMA concerning vacancies on various councils and committees and, upon motion of Dr. Thatcher and a second by Dr. Clark it was moved to recommend Dr. Kenneth G. Kohlstaedt for appointment to the Council on Scientific Assembly and that the vacancies be called to the attention of the general membership through the Newsletter.

A LETTER FROM INDIANA UNIVERSITY seeking recommendations for nominations for a full-time director of the Northwest Center for Medical Education was reviewed and the secretary was advised to notify the membership of the Association through the Newsletter of this vacancy.

A LETTER FROM WILLIAM T. PAYNTER, M.D., COMMISSIONER OF THE INDIANA State Board of Health, in reply to our recommendations for Health Service Areas was read and taken as a matter of information.

A PROPOSAL FOR THE CONSOLIDATION OF INDIANA PHYSICIANS SUPPORT AGENCY and the Professional Standards Review Council which had been distributed to the members prior to the meeting was taken as a matter of information upon motion of Dr. Thatcher and a second by Dr. Ingram.

THE ACTIVITIES OF THE RETAIL CREDIT COMPANY and others in obtaining patient information from physicians' records for insurance carriers was again discussed and the secretary called attention to Report F of the Council on Medical Services of the AMA and the actions which had previously been taken by the Association. Upon motion of Dr. Thatcher and a second by Dr. Ingram, it was voted that the Executive Committee of the Indiana State Medical Association go on record that physicians should give no information to parties seeking to copy patients' records unless the physician checks with the patient to be sure he understood what use is being made of this information. In reviewing the opinion of the attorney, given sometime ago, the physician should receive a personal authorization from the patient. The secretary was also instructed to call this to the attention of the membership in the next issue of the Newsletter.

LETTER FROM INDIANA HEALTH CAREERS, INC., seeking a contribution was reviewed and, upon motion of Dr. Thatcher and a second by President Wilhelmus, a contribution of \$50 is to be sent.

A COPY OF THE RECOMMENDATIONS OF THE AMA REGARDING GUIDELINES FOR Housestaff Contracts or Agreements, copies of which had been distributed to members of the Executive Committee, was next discussed. Following discussion, upon motion of Dr. Ingram and second by Dr. Thatcher it was determined that these agreements are matters to be considered at the local level and not at the state level.

A LETTER FROM THE INDIANA STATE NURSES ASSOCIATION addressed to President Wilhelmus concerning the State Joint Practice Commission was thoroughly discussed and the Presi-

dent was requested by consent to formulate a letter in reply.

MINUTES OF THE MEETING OF THE COMMISSION ON PUBLIC INFORMATION were reviewed and the section pertaining to their proposal to prepare some short spot items for use on television was reviewed and, upon motion of Dr. Thatcher and a second by Dr. Ingram, the Commission is to be advised that they can proceed but any expenses for this activity would have to come out of the Speakers' Bureau funds and they could not exceed the unencumbered balance in this fund. The Commission is also to be advised that, inasmuch as the funds come from doctors throughout the state, any use of these spots should not be limited to any one locality but should, therefore, cover the entire state.

LETTERS FROM SEVERAL STATES ANNOUNCING THEIR CANDIDATES for the June meeting of the AMA were reviewed for the information of the committee.

PRESIDENT WILHELMUS REPORTED ON THE MALPRACTICE BILL, H.B. 1460, and will report more in detail at the next meeting of the Board. He did ask the committee to support his action in removing the physician's assistants portion of the bill from the contents of H.B. 1698 as he felt we could not have the bill adopted otherwise. By consent, his action was approved.

THE JOURNAL

Request for advertising space by Retail Credit Company was turned down upon motion of Dr. Ingram and a second by Dr. Thatcher.

A request for space in THE JOURNAL from the Agency Premium Services, Inc., was approved on motion by Dr. Ingram and a second by President Wilhelmus.

THE JOURNAL has raised the question about their funds paying the total charge of the Newspaper Clipping Service, many of which are for the benefit of the Association and not usable for THE JOURNAL. Upon motion of Dr. Thatcher and a second by Dr. Clark the charges for this service are to be prorated between THE JOURNAL and the Association.

REPORT FROM THE STATE JOURNAL ADVERTISING BUREAU together with the financial statement for the 1973-1974 operations were reviewed and taken as a matter of information.

MEDICAL DEFENSE

The secretary advised the committee that, in accordance with their official request, the attorneys for a New Albany physician had filed a copy of their answer to the charges of the plaintiff with the Association.

A REQUEST FROM THE COMMISSION ON EMERGENCY MEDICAL SERVICES to send a representative to a STEP Conference on Emergency Medical Services to be held at Indianapolis on May 5, 6 and 7, was reviewed by the committee and, by consent, it was agreed that a member of the Commission could attend.

NATIONAL CONFERENCE FOR HEALTH SERVICE LEADERS, May 6-8, no representative will be sent.

NATIONAL CONFERENCE OF

STATE LEGISLATURES for the purpose of discussing malpractice was called to the attention of the committee and the secretary reported that Hon. Adam Benjamin, Jr., a state senator, and Mr. James Stewart, association legal counsel, were both on the program. This was taken as a matter of information.

AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE in Des Moines, May 9-10, no representative will be sent.

NEW BUSINESS

The secretary presented for the committee's review the contract of Blue Cross-Blue Shield for the headquarters staff for the coming year and called attention to the fact that the rate had been increased about \$20 per year per employee. By consent, the secretary was authorized to sign the contract.

A LETTER FROM THE CENTER FOR INNOVATION IN TEACHING THE HANDICAPPED to be conducted by the School of Education of Indiana University was received and it was approved, upon motion of Dr. Thatcher that the Association would pay the \$15 registration fee only and suggested that Dr. Middleton might like to attend this meeting.

The secretary quoted from the News Report of HEW that "because of current situation, we probably will not be able to fund more than 20 new planning PRSOs during the fiscal year."

There being no further business the committee ajourned to meet again at 6:00 p.m., Sat., June 7, 1975, in the headquarters building.

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GENERAL SURGEON wants to relocate in Indiana; prefers small community and solo practice; many years experience; good references. Box 401, THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

POSITION DESIRED

Physician's Assistant student who will graduate Aug. 16, 1975, from I.U. program requests communication with potential employer interested in serving as preceptor for last months of clinical training. Contact Samuel G. Shorter, 256 Washington Center Road, Apt. D, Fort Wayne 46825; telephone 219-483-3516.

ONE OR TWO PHYSICIANS for Family Medicine being sought. Town of 9,000 with a service area of 24,000. Located in West Central Indiana. 108 bed hospital, JCAH Accredited. For further information contact S. R. Farid, M.D., Chief of Staff, Clay County Hospital, 1206 East National Avenue, Brazil, Indiana, 47834.

OB-GYN and UROLOGY specialties to join an established successful practice with 16-man multi-specialty group. Excellent group benefits; retirement plan; modern clinic facilities; progressive community with excellent educational system including two colleges; area population 75,000; great recreational facilities; must be board eligible or certified; Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220

PURDUE DEFIBRILLATION CONFERENCE

The Biomedical Engineering Center of Purdue University will hold a conference in Lafayette, Indiana, from October 1 to 3, 1975, covering the practical and clinical aspects of cardiac defibrillation. The speakers have been selected based upon their positions as leaders in their respective fields. The topics to be discussed include clinical, basic science, and engineering aspects of electrical defibrillation as it pertains to the needs of physicians, nurses, emergency medical personnel, hospital engineers, equipment manufacturers, and research scientists. The state-of-the art of defibrillation techniques will be presented and examined critically and a major goal of this three-day conference will be to integrate all available technology for optimization of ventricular defibrillation. The registration fee of \$95 includes proceedings and two luncheons.

For further information, please Write: Division of Conferences and Continuation Services, Stewart Center, Purdue University, West Lafayette, Indiana 47907; or Phone: (Area Code 317) 749-2533

U.S. PENITENTIARY, Terre Haute, Ind., needs a medical officer for small 35-bed JCAH accredited hospital. No administrative duties. 40 hours per week. Liberal Civil Service benefits. 20-year retirement. Malpractice insurance not required. Salary to \$36,000, depending upon qualifications. An EEO employer. Call or write: J. M. Kemp, Personnel Officer, U.S. Penitentiary, Terre Haute, IN. 812-238-1531.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be consid-

ered for display type advertising.

Charges for commercial announcements are:

15¢ for each word

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Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month PRECEDING month of issue.

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Are you getting just a little weary of the pressures of private practice? Are there not enough hours in the day to leave anything for leisure time? Are the increasing costs of running your office and high taxes eating up your actual income? If so, why don't you consider hospital practice in one of our agencies and solve a lot of these problems.

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The agencies where we currently have opportunities are located in small communities where the pace of life is a little more casual and where you will be able to enjoy your leisure time in the excellent recreational facilities our state has to offer.

Why not send us a copy of your up-to-date curriculum vitae and see what can be worked out.

All applicants must possess or be eligible for a permanent license to practice in Michigan.

Ivan E. Estes, Personnel Director
Michigan Department of Mental Health
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WANTED—CHIEF MEDICAL OFFICER to activate and direct a modern VA Ambulatory Care Clinic in Evansville, Indiana. Clinic will utilize many of the newest concepts in health care delivery and is scheduled to open soon. Beginning salary up to \$36,000 depending on qualifications. 30 days vacation, 15 days sick leave, educational opportunities and many benefits. Licensed in any state. An Equal Opportunity employer. Contact Chief of Staff, VA Hospital, Marion, IL 62959 Tel: 618-993-2151.

GENERAL SURGEON, board eligible, wishes to relocate. Willing to do some general practice. Prefers solo, small city with good hospital. Good references. Indiana license. Available immediately. Box 400, THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.



"WELL, WHAT DID HE THINK OF YOUR SPEECH FOR TONIGHT?"

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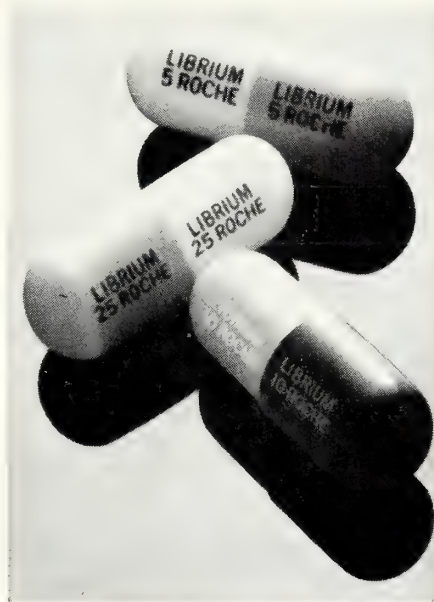
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards.

Precautions:

ORAL: In the elderly and debilitated and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six.

INJECTABLE: Keep patients under observation, preferably in bed, up to three hours after initial injection; forbid ambulatory patients to operate vehicle following injection; do not administer to patients in shock or comatose states; use reduced dosage (usually 25 to 50 mg) for the elderly or debilitated and for children age twelve or older.

ORAL AND INJECTABLE: Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating compounds such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual



precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduc-

tion; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

With the injectable form, isolated instances of hypotension, tachycardia and blurred vision have been reported; also hypotension associated with spinal anesthesia, and pain following I.M. injection.

Usual Daily Dosage: Individualize for maximum beneficial effects. **Oral: Adults:** Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* **Geriatric patients:** 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

For Parenteral Administration: Should be individualized according to diagnosis and response. While 300 mg may be given during a 6-hour period, do not exceed this dose in any 24-hour period. To control acute conditions rapidly, the usual initial adult dose is 50 to 100 mg I.M. or I.V. Subsequent treatment, if necessary, may be given orally. (See Precautions.)

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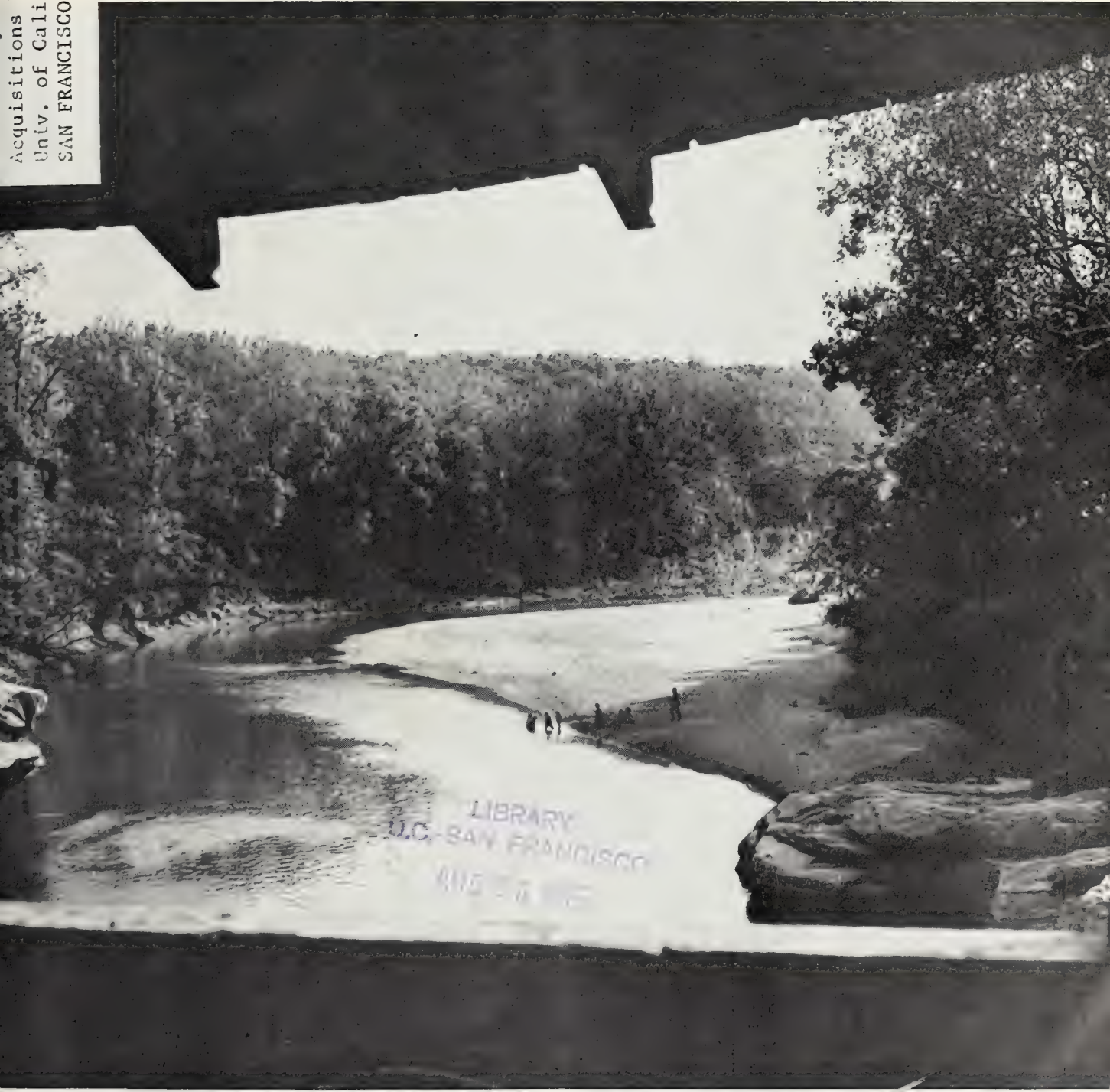
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August 1975 • Vol. 68 • No. 8 • Indianapolis

The JOURNAL

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depressive
symptoms

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

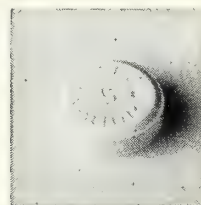
respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



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anxiety states
with associated
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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

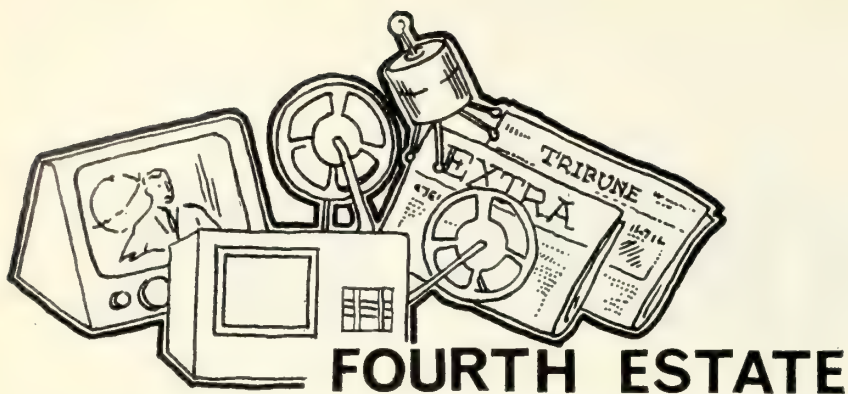
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Pioneer Malpractice Law

In the May 12 issue of *People Weekly*, a veteran physician in charge of assessing the malpractice dilemma for the Department of Health, Education, and Welfare was asked how he would handle huge malpractice premiums if he were a doctor just starting his practice.

Dr. Roger Egeberg's answer was, in part, that he'd consider moving to a state such as Indiana where "the (malpractice) laws are more reasonable."

We doubt that our state's new malpractice bill will spawn a surge of new doctor's shingles. But it does put us in "the only roulette wheel in town" category because Indiana is one of the few states which has attempted to tackle the malpractice mess. Our legislators should be commended for taking the lead in trying to solve what has become a national crisis.

The act will become effective July 1, with the exception of a section al-

lowing \$1.5 million for a Residual Malpractice Insurance Authority, which is effective now. The act limits an individual doctor's responsibility in a malpractice case to \$500,000 and any one insurance carrier's liability to \$100,000 per case. Awards of more than \$100,000 would be financed by the state from a patient's compensation fund financed by surcharges of up to 10% on malpractice premiums.

A review panel composed of three physicians and one nonvoting attorney will be created to study each claim and determine whether malpractice has occurred. The review board's decision will be admissible in court but not binding. Members of the screening panel will be available as witnesses.

Gov. Bowen praised the bill as "not a doctor's bill, not a lawyer's bill, but a bill for the people." However, both physicians and lawyers often were less than humanitarian during hearings on the bill, dwelling on inane or frivolous issues the bill

and its review panel are designed to eliminate.

Obviously time will measure the bill's effectiveness. And, wisely, the legislature appointed a fault-finding committee to examine the malpractice problem and report back to the 1976 session.

Whatever solutions are needed should be left to the states rather than to another, glorious Federal bureaucracy. The legislative commission would do well to consider Dr. Egeberg's suggestion limiting a lawyer's contingency fee to 30 to 40% of the first \$100,000 followed by a proportionately scaled-down fee. Juries also could make awards for annual payments rather than a lump sum.

With these considerations and the knowledge time brings, Indiana could become a desirable settling place not just for a doctor but for a lawyer and Mr. Average Citizen, too.—**Vincennes Sun-Commercial**, May 25, 1975.

Indiana Medical Foundation

The Indiana Medical Foundation was organized to furnish support for the educational activities of the Indiana State Medical Association. These activities include programs for continuing education and the scientific publications of *The Journal*. Contributions made to the foundation are deductible by donors in accordance with the Internal Revenue Code. Bequests, legacies and gifts are deductible for federal estate and gift tax purposes. Memorial contributions made to the foundation will be formally recorded and acknowledgment will be sent to the family. Gifts, bequests, and memorial contributions may be mailed to the foundation at 3935 N. Meridian St., Indianapolis 46208.

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Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 3935 N. Meridian St., Indianapolis 46208. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 1st of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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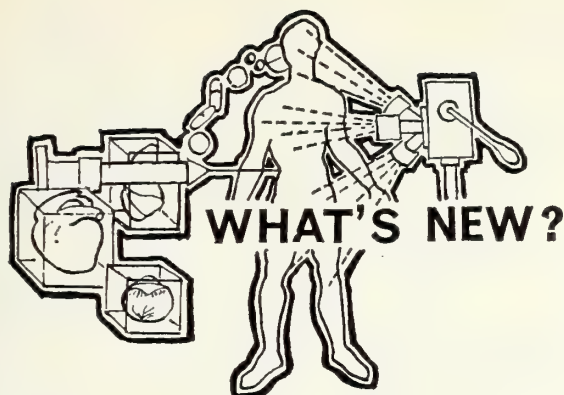
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take as needed

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* * *

McGraw-Hill has published a book of medical advice for the layman—"What You Should Know About Health Care Before You Call a Doctor." Its author is G. Timothy Johnson, M.D., who is the star of a Boston-based television show called HOUSE CALL. Dr. Johnson is a Fellow in Continuing Education at Harvard Medical School. The price is \$6.95 for hard cover. \$3.95 for soft cover.

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Dome Laboratories has received FDA approval to market DTIC-Dome (imidazole carboxamide). The drug has proven helpful in treating metastatic malignant melanoma. Dome has commenced distribution to cancer treatment centers and other qualified hospitals.

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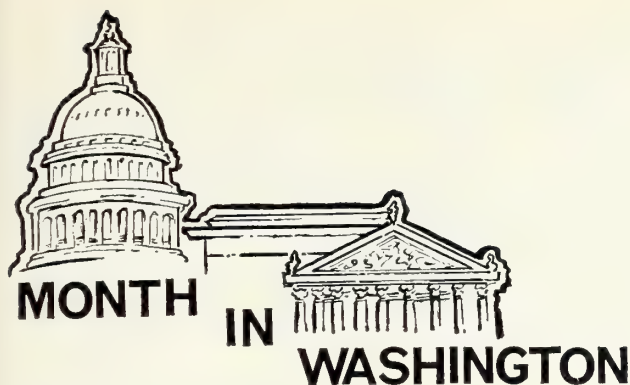
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4.	Robert P. Acher, Greensburg	Lanny Copeland, Osgood	Greensburg
5.	Robert C. Oehler, Brazil	Nancy L. Oehler, Brazil	Brazil
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10.	Joseph M. Siekierski, Griffith	James R. Brown, Valparaiso	Sept. 24, 1975, Valparaiso
11.	George W. Wagoner, Delphi	Fred Poehler, La Fontaine	Sept. 17, 1975, Delphi
12.	J. Robert Edwards, Auburn	Thomas A. Felger, Fort Wayne	Sept. 11, 1975
13.	John O. Hildebrand, Jr., South Bend	David L. Spalding, Mishawaka	Sept. 10, South Bend



This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

THE UNUSUAL ONE-DAY "PUBLIC OVERSIGHT" hearings of the House Ways and Means Committee's Health Subcommittee to determine if the Department of Health, Education, and Welfare is superseding Congressional intent in an increasing number of Medicare cost-control regulations was marked throughout by angry confrontation between the HEW Secretary and health providers.

Undaunted by a solid array of heated opposition from medical and hospital groups, Secretary Caspar Weinberger told the Subcommittee that the four disputed Medicare regulations will save about \$250 million a year and "improve the quality of care."

The hearing bringing together Weinberger and his critics was called by Subcommittee Chairman Dan Rostenkowski (D-Ill.) who said he was sorry the confrontation had to take place. "I hope the Subcommittee can remove roadblocks. We should really try to get the government and the health care industry out of the courtroom and into the conference room where the debate belongs."

Four lawsuits have been filed against the HEW Department to overturn the regulations. Members of hospital and physicians' groups, including the American Medical Association, urged the lawmakers at the hearing to crack down on HEW for going beyond the intent of law. But there was little indication from the Subcommittee that any swift action is contemplated.

Weinberger, easily fielding most of the Subcommittee's questions, refused to acknowledge any merit in the private sector's slashing attacks on the regulations, insisting the regulations followed the intent of Congress and were needed to curb costs. He suggested the remedy would be in seeking to have Congress change the laws, rather than in suing HEW.

The regulations under fire:

- Social Security's Utilization Review (UR) final regulations requiring elaborate institutional post-admission review mechanisms.

- Reducing the schedule of limits on hospital inpatient general routine service costs from the 90th to the 80th percentile.

- Limitation on recognition of physicians' prevailing charge increases, based on an economic index.

- Termination of the inpatient routine nursing salary cost differential.

Stressing a common theme among the witnesses, the AMA cited "a general feeling of futility concerning administrative action felt by the public as a whole, but especially by groups subject to and particularly affected by federal regulations." Ernest T. Livingstone, M.D., chairman of the AMA Council on Legislation, said many professional associates display "an attitude often of exasperation, consternation and indignation with respect to the bureaucratic administration of government programs.

"Administrative regulations," Dr. Livingstone said, "often expand upon or subvert the intent of Congress." This is why, he explained, the AMA, for the first time in its history, recently sued the HEW Department over the UR regulations. Federal Judge Julius Hoffman upheld the AMA's contentions and issued a restraining order against carrying out the UR rules. The HEW Department has recommended that the case be appealed.

A key AMA argument was that admission review within 24 hours is directed almost solely to protect hospitals against possible non-reimbursement—not the patient's health. Judge Hoffman said that if "patients who cannot pay cannot be hospitalized when diagnosis is unclear, the potential injury to the patient's health may be irreparable."

Edgar T. Beddingfield, M.D., vice-chairman of the AMA Council on Legislation, said HEW barged ahead on the physicians' Medicare fee index without giving interested parties a chance to question the details of the regulations. There is no justification in either the law or its legislative history for imposition of a national economic index, Dr. Beddingfield told the panel, noting that Medicare fee recognition "has long lagged behind current trends in physicians' fees. Because of the unique two-year delay, he said the index limitations could result in shifting the financial burden to Medicare-Medicaid patients by driving reimbursement further below realistic fees.

Also criticizing the Medicare fee constraints, John Alexander McMahon, president of the American Hos-

Continued

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pital Association, said "this unilateral arbitrariness is precisely the problem with the general approach to program economic controls adopted by the Social Security Administration in carrying out its responsibilities. It clearly suggests that SSA continues to utilize law to suit its own concerns and not to reflect in a careful and publicly acknowledged way a commitment to honor legitimate costs in the delivery of health care."

THE PHYSICIANS' MEDICARE FEE INDEX, angrily debated by the AMA and the HEW Secretary during the Ways and Means Health Subcommittee "public oversight" hearing, limits reimbursement to 17.9% above levels prevailing in fiscal year 1973.

Now in effect, the new payment formula, according to HEW Secretary Weinberger, will save the government an estimated \$26 million during this fiscal year out of a total Medicare Part B outlay of \$3.2 billion.

Most of the objections to the national formula which is pegged to various cost-of-living indexes were brushed aside by HEW and Social Security in issuing the regulations in final form.

The AMA has charged that Congress intended local, rather than national, indexes; that the limitation was not supposed to be on a procedure-by-procedure basis but an aggregate; and that HEW allowed insufficient time for discussion on the manner in which it has decided to draw up the index. The control will simply force more physicians to abandon the assignment method, AMA warned.

Weinberger argued that while the Senate Finance Committee report suggested that a separate index for each locality be calculated, "a national index is being used, at least initially, because the data required to construct local indices are not now available."

The index will be applied to every prevailing charge in each locality. It will also be applied on a cumulative basis with fiscal 1973 serving as the base year. Increases in prevailing charges over the 1973 base year level cannot exceed the rate justified by the economic index calculated for that period.

Any individual prevailing charge that would increase by more than 17.9% over the 1973 base level will have its rate of increase limited to 17.9%. Prevailing charges that have increased by less than 17.9% will be unaffected. Any portion of the allowable increase not used will be carried forward to future years.

Because physicians are incorporating in increasing numbers, Internal Revenue Service data are no longer a good source of information about changes in physicians' office practice expenses, Weinberger said. Pertinent components of the Consumer Price Index, the Wholesale Price Index, Bureau of Labor Statistics wage indices, and data from Medical Economics were used instead.

Continued



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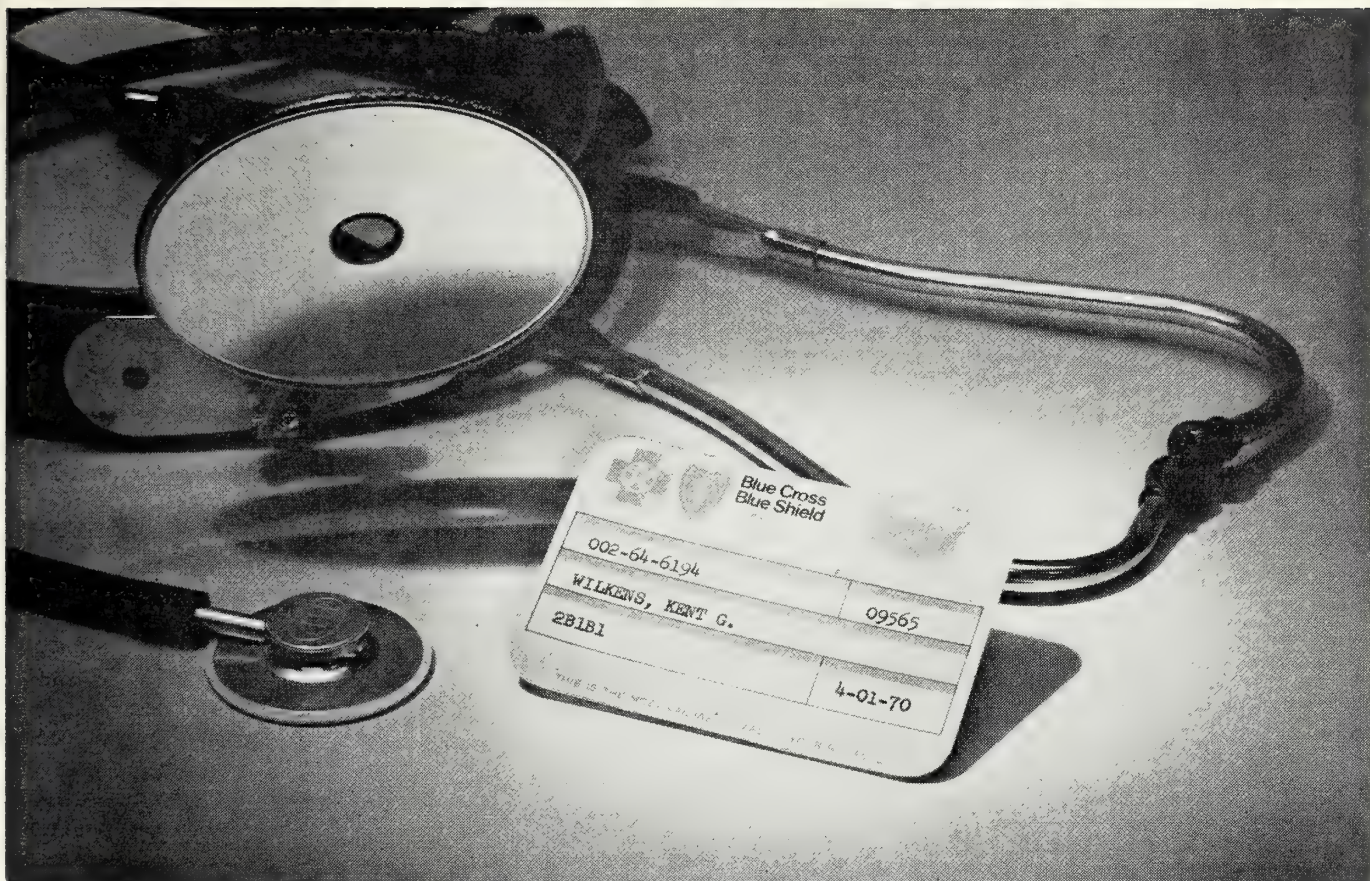
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F. DAVID MATHEWS, 39-YEAR-OLD PRESIDENT of the University of Alabama, has been selected by President Ford to be the new secretary of the Health, Education, and Welfare Department.

Incumbent Secretary Casper Weinberger has said repeatedly in recent months he wished to return to California. He was not ousted from the post. His resignation is effective Aug. 10, 1975.

Mathews is supposed to be more liberal than Weinberger, whose chief forte was economy and rigid controls to effect economy. Completely unknown on the national political scene, the youthful University president has described himself as an independent. Rumor has it that he is at odds with Alabama Governor George Wallace.

A Phi Beta Kappa graduate of the University of Alabama, Mathews holds a Ph.D. in history from Columbia University. He has been with the state university since receiving his doctorate.

Whatever Mathews' other qualifications, the White House obviously had some 1976 political considerations in mind in tapping the southerner from Wallace's state.

The Senate must confirm Mathews for the post, but no troubles are seen.

As HEW Secretary, Mathews will be at the center of domestic controversies, including welfare, social security, education and the big federal health programs. He will spearhead the Ford Administration's expected drive for its own national health insurance program next year. He will also have to cope with the lawsuits filed by medical and hospital organizations against control regulations imposed by Weinberger. And there's always the vexing and apparently insoluble problem of straightening out the organizational mess at HEW.

THE ASSOCIATION OF AMERICAN MEDICAL Colleges (AAMC) has filed suit to prevent the Department of Health, Education, and Welfare from implementing Medicare-Medicaid hospital cost-control regulations that became effective July 1, 1975.

The action seeks a preliminary injunction against regulations which set limits on routine service costs in short-term, non-federal hospitals.

AAMC says the regulations fail to consider factors in hospital-cost measurement that Congress wrote into law; namely, the scope of services offered, the quality and intensity of care, and hospitals' educational programs. As a result, many hospitals' daily costs will soar far beyond the amounts allowed, AAMC says.

HEW's reimbursement schedule for these routine daily costs groups hospitals according to their urban or non-urban location, area per-capita income, and bed number. Similar interim regulations have been in effect for the past year, but at a higher reimbursement rate.

"If these new regulations are allowed to stand, Medicare patients could lose up to \$68 million worth of hospital services next year," said John A. D. Cooper, M.D., president of AAMC.

Medicaid charges also will be affected, he points out, since by law, Medicaid hospital charges cannot exceed those of Medicare. Other third-party payers are likely to use the new schedules in setting payment rates, he added.

"The new ceilings for payments will work a tremendous hardship on U.S. hospitals," he said. "More importantly, they will, for the first time since Medicare began, place many Medicare patients in jeopardy of having to pay for a portion of their hospital costs."

Particularly hard hit would be the nation's teaching hospitals, said Charles Wolman, administrator of Yale-New Haven Hospital, New Haven, Conn. AAMC estimates 733 hospitals, about 12.8% of the total, would be adversely affected.

"John Hopkins University Hospital, in Baltimore, would have a maximum (for daily routine charges) of \$120," he said, "while D.C. General Hospital, 34 miles away, would be allowed \$174.

"Duke University Hospital (in Durham, N.C.) would be allowed \$89 while nearby Charlotte, N.C., Memorial Hospital would receive \$120."

Wolman's own hospital, Yale-New Haven, has been allotted a daily allowable charge of \$174.

"Duke suffers, for instance, because of a low per-capita income level in its area. Duke's costs are probably 10-15% less than ours, due to lower labor costs," said Wolman, "but they certainly are far more than half as much."

Interim regulations have been in effect for the past year which set Medicare daily hospital charges at the 90th percentile of the national total. The new regulations lower this to be 80th percentile.

"The interim regulations . . . have many of the serious faults of the new regulations," said Dr. Cooper. "We decided to live with them for a year, and not take legal action earlier, because the secretary promised in a press release June 6, 1974, that the revisions would incorporate criteria which would make them less arbitrary and capricious. It is obvious that he has not kept his promise, and our only recourse is in the courts." ◀

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State Supreme Court's Schedule of Maximum Contingent Fees Upheld

The state Supreme Court was authorized to adopt a graduate schedule of contingent fees for use in tort litigation, including malpractice suits, the New Jersey Supreme Court ruled.

After the Supreme Court adopted the contingent fee schedule, several associations of trial lawyers brought an action challenging the adoption of the fee schedule. A state trial court ruled that the fee schedule was invalid. An appellate court later reversed that decision on the ground that adopting the fee schedule was within the scope of the court's power to control the practice of law.

The fee schedule imposed the following limits on contingent fees attorneys can charge for product liability and negligence claims:

- (1) 50% on the first \$1,000 recovered;
- (2) 40% on the next \$2,000 recovered;
- (3) 33-1/3% on the next \$47,000 recovered;
- (4) 20% on the next \$50,000 recovered;
- (5) 10% on any amount recovered over \$100,000;
- (6) where the amount recovered is for the benefit of an infant or incompetent and the matter is settled without trial the foregoing limits shall apply, except that the fee on any amount recovered up to \$50,000 shall not exceed 25%.

On appeal to the Supreme Court, the court said that under the New Jersey constitution the New Jersey

Supreme Court was granted the exclusive responsibility to regulate the practice of law. No hearing was necessary before issuing the regulations. Mindful of the abuse that the fee schedule was adopted to control, the court said that it reversed the power to modify or repeal the fee schedule and attack the problem in another way.—*American Trial Lawyers Association, New Jersey Branch v. New Jersey Supreme Court*, 330 A.2d 350 (N.J.Sup.Ct., Dec. 17, 1974).

Editor's Note: A prior decision in this case was reported in THE CITATION, Vol. 29, No. 7, p. 97.

Hospital not Liable for Patient Injuring Himself

A trial court had properly found a hospital not liable for injuries suffered by a patient through his own act, an Indiana appellate court ruled.

The patient had been hospitalized for treatment of ulcers and was required to have a 24-hour urinalysis test. He was to void into a urinal during the 24-hour period and transfer the urine into a one-gallon plastic jug containing hydrochloric acid. Instead of voiding into the urinal, the patient voided directly into the jug and suffered severe and painful burns to his penis when the acid reacted with the urine.

Claiming that the nurse had not properly advised him on the procedure for collecting urine, the patient and his wife brought an action against the hospital.

At the time of trial, the patient testified that he suffered pain upon urination or upon sustaining a partial erection. He also testified that the injury created a psychological

problem which caused him to be impotent.

His wife claimed damages for loss of consortium. A jury found in favor of the hospital, and the patient and his wife appealed.

On appeal, the court affirmed the trial court's verdict over several objections by the patient and his wife. They contended that the trial court erred in instructing the jury on the issue of contributory negligence and in using the phrase "proximate cause of the accident" throughout the instruction. The court said that it was not prejudicial to give the instruction on contributory negligence.

Although it was not error to use the word "accident," the appellate court recommended that its use be discontinued. One of the interpretations of "accident" is that there was no fault by either party, the court said.

Another contention on appeal was that the trial court improperly instructed the jury that it could reject or refuse to consider testimony by any witness. The patient claimed that this instruction permitted the jury to reject the testimony of a psychologist and accept that of several psychiatrists. The appellate court rejected that contention, saying that the instruction did not single out a particular expert witness.

Other claims of error were also rejected by the appellate court in affirming the trial court's judgment.—*Chamberlain v. Deaconess Hospital, Inc.*, 324 N.E.2d 172 (Ind. Ct. of App., March 3, 1975).

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Clinical Experience with Operative Staging for Assessment of the Extent of Involvement in Hodgkin's Disease

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ALTHOUGH the etiology of Hodgkin's disease remains unknown, great strides have been made in its diagnosis and treatment. Review of the recent literature demonstrates that earlier and more accurate diagnosis of Hodgkin's disease results in better treatment and longer survival.^{1,2,3,4,5,6} Glatstein and associates first suggested exploratory laparotomy to assess the spleen, liver and intra-abdominal lymph nodes for involvement prior to institution of therapy.⁷ Several reported series have shown that this procedure increases the accuracy of staging in every case and, in addition, incurs little risk for the patient.^{3,4,5}

The present experience of the Indiana University Medical Center covers 34 patients and confirms the concept that surgical staging results are unequalled by clinical assessment with or without lymphangiography, and there is little operative risk.

From the Departments of Surgery and Medicine, Indiana University School of Medicine, Indianapolis 46202.

Methods

The most common initial complaint in this group of patients was lymph node enlargement, usually in the cervical or supraclavicular areas. In most instances the patients had undergone biopsy with a diagnosis of Hodgkin's disease made at their local hospitals. All slides were reviewed by our pathologists for histologic confirmation and classification. On admission to the hospital, careful attention was given to the history and physical findings to determine the presence of systemic symptoms and distant spread of disease. Routine blood and urine determinations, bone marrow examination, liver function tests, chest x-ray, liver-spleen scan, and abdominal lymphangiography were done in each patient. Preoperative staging was then established according to the Rye International classification⁸ and recorded on a specially designed form (Fig. 1).

Patients with obvious Stage IV disease were not explored and were treated with chemotherapy.

The staging procedure was similar to that originally described by Glatstein et al.⁷ and included splenectomy; wedge and needle biopsy of the liver; careful examination and biopsies of periaortic, celiac, mesenteric, and periportal lymph nodes. Metallic clips were placed to mark the splenic hilum and all lymph node biopsy sites to assist with localization of radiation therapy. Oophorectomy was done in females of child-bearing age with hopes of protecting ovarian function during radiotherapy. The histopathology was reported according to the Lukes' classification: Lymphocyte depletion, lymphocyte predominance, mixed cellularity and nodular sclerosing varieties.⁹ In all cases Reed-Sternberg cells were seen. This was a prerequisite to making the diagnosis of Hodgkin's disease.

Following staging, the treatment of patients with Hodgkin's disease was as follows:

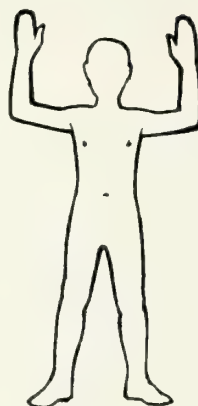
Stage I and II (all histopathologic types) received radiation therapy to the involved and contiguous nodal areas. In addition, some his-

Sites Clinically Involved
Check Appropriate Box

Area	Normal	Involved
Nodes		
Cervical	()	()
Axillary	()	()
Inguinal	()	()
Other	()	()
Mediastinum	()	()
Spleen	()	()
Liver	()	()
Other	()	()
Lymphangiogram	()	()

Pre Op Stage		
I	()	A ()
II	()	
III	()	B ()
IV	()	

FIGURE 1



sclerosing type. The remainder were distributed randomly among the remaining types (Table 1). Two patients who were eventually diagnosed as reticulum cell sarcoma are included in this series since they were staged and treated in a similar fashion.

A 24% disparity was noted between the clinical and operative staging (Table 2). Four patients had more, while four patients had less disease than suspected pre-operatively. Three lymphangiograms presented falsely positive adeno-graphic patterns and four were falsely negative. These results are similar to other series and they confirm our plan to continue with staging, rather than relying totally on clinical and lymphangiographic impressions.

Three patients had postoperative complications: mild pancreatitis (Stage II A), wound dehiscence (Stage III A), and a subphrenic abscess plus wound infection (Stage IV B). These serious complications occurred in patients with more advanced disease. In addition, a number of patients had unexplained fever postoperatively, which was assumed to be a result of the Hodgkin's disease or thrombosis of the splenic vein. No etiology for the fever was ever found. There were no postoperative deaths.

Discussion

The staging procedure significantly improved the accuracy of our assessment of the extent of the Hodgkin's disease in this group of patients, and resulted in relatively few complications (9%) and no operative mortality. Thus, we had the means for more accurate planning of radio-and/or chemotherapy. When radiation therapy was used, lower dosages were required in the left upper quadrant since the spleen had been removed. This diminished radiation pneumonitis and radiation nephritis of the left kidney. In addition, there is an improved hemopoietic tolerance to combined chemotherapy following splenectomy.¹¹

A definite relationship exists between clinical stage and survival.

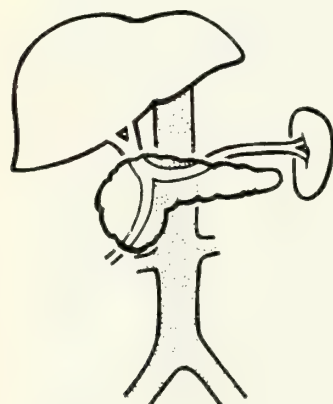
Operative Date
Surgeon

Pathology

Organ	Normal	Involved
Spleen	()	()
Liver	()	()
Periaortic	()	()
Nodes	()	()
Portal		
Nodes	()	()
Other	()	()

Cell Type

Post Op Stage		
I	()	A ()
II	()	
III	()	B ()
IV	()	



Indicate Biopsy Sites

topathologic varieties received extended field radiation therapy. Patients with stage III Hodgkin's disease with lymphocyte predominance were treated by extended field radiation therapy and all other histopathologic types of stage III underwent combination chemotherapy. Stage IV patients were treated with combination chemotherapy consisting of nitrogen mustard, Oncovin, procarbazine, and Prednisone (M.O.P.P.), in a regular program of serial treatment. More recently

bleomycin has been added to this chemotherapeutic regimen.

Although it is too early to report our long term results, it would seem that they are thus far similar to other reported series.¹⁰

Results

The 34 patients ranged in age from 11-62 years and there were twice as many males as females. A large proportion (23/34) were found to have mixed cellularity disease, while 6/34 had the nodular-

Appropriate treatment requires a better definition of the spread of disease in each and every patient, in order to avoid excessive or inadequate therapy. If this can be accomplished with little risk to the patient, there is justification for the use of exploratory laparotomy and splenectomy in the diagnostic assessment of patients with newly discovered lymphomatous disease.

TABLE 1
HODGKIN'S DISEASE
IUMC — 1969-72

	Total #	Mixed	Nodular sclerosis	Lymphocytic predominance	Lymphocytic depletion	Reticulum cell sarcoma
Male	23	17	3	2	0	1
Female	11	6	3	0	1	1
Totals	34	23	6	2	1	2

TABLE 2
STAGING PROCEDURE RESULTS

Postop Stage Worse	# patients	Postop Stage Better	# patients
I to III	1	II to I	1
II to III	1	III to I	1
III to IV	2	III to II	2
	<u>4/34</u>		<u>4/34</u>

26/34 patients had same postop stage
8/34 (24%) of patients changed stage

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About Our Cover

A view of Sugar Creek (downstream) as seen from inside the famous Narrows covered bridge at Turkey Run State Park graces our August cover.

The area had been used for many years by nature lovers and seekers of outdoor pleasure. "But seekers of pleasure do not always revere God's gifts or spare the charm and quiet loveliness of natural surroundings. And too often the public fails in its duty to protect these gifts and preserve them from the hand of the despoiler, for the admiration, joy and comfort of future generations," Governor Samuel M. Ralston advised the Turkey Run Commission on April 27, 1915, when he appointed its members.

Thus, in 1916, Turkey Run became Indiana's second State Park, preserving one of the greatest natural areas in the state.

Sugar Creek roams through the park creating magnificent gorges and lovely waterfalls. It was called **Ke-an-kik-se-pe** by the Kickapoos and Piankeshaw Indians who roamed the area.

Sugar Creek is of considerable geological interest. It was formed by glacial meltwater some 20,000 years ago, and the water course cut through the original upland and exposed sandstone, shale and siltstones deposited in preglacial times.—**Photo by Ken Williams, Department of Natural Resources, State of Indiana.**

Immunology of Malignancy

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A study of spontaneous remission of malignancy was started by Cole.¹ He found that there were quite a number of spontaneous remissions of malignancies. A review of the tissue removed confirmed the presence of malignancies. He postulated that there was something in the immune mechanism of the host which either caused the malignancy to grow or to cease growth.

It was also noted that when organs were transplanted, and the host was placed on immunosuppressant drugs, malignancies occurred at a much greater rate than could be expected in the normal organ. It was not surprising, therefore, that when the immunosuppressant drugs² were discontinued, the host was able to overcome the malignant growth, and there was a spontaneous remission. At a later date, when the organ itself began to be rejected and the immunosuppressant drugs were re-started, the malignancy became rampant again. The incidence of malignancy in the host who had received the organ transplant was at least 1,000 times the normal expectation.

It was later noted that malignancies occurred more often in conditions where there was either a congenital or acquired defect in the immune mechanism, and where there was a loss of delayed hypersensitivity.³ Investigators⁴ later noted that in autoimmune diseases (such as pernicious anemia, ulcerative colitis and mumps orchitis) malignancies were much more common than in the normal population.

The immune system consists of two populations of lymphoid cells mediating specific cellular and humoral immunity, together with the

biological systems which amplify specific immunologic reactions.⁵ These provide the major defense mechanism against infection and malignancy. Included among the amplification systems of specific immunity are the complement system, the inflammatory response, the chemical mediators of cellular and anaphylactoid immunity, the activated flagellocytic cells and their intracellular killing mechanisms.

Circulating T-cells from the blood of a patient with cancer can kill the patient's own cancer cells grown in cell culture. However, when mixed with serum from the same patient, this cytotoxic effect may be completely blocked. This blocking is believed to be caused mainly by tumor-specific IgG antibody, combined with tumor cell-membrane antigen, or with free tumor antigen circulating in the body fluids.⁶ Thus, we have the complex situation where one form of immune response—the cell-mediated response—is capable of inflicting great damage to the cancer, but is effectively inhibited in this role by the alternate form of immune response, mediated by antibody and antigen-antibody complexes.

Injection of serum from a patient with a particular form of cancer into another patient with a similar cancer may increase the degree of blocking of the immune T-cell and lead to more rapid spread of the cancer. There is good evidence that the regression of lymphadenopathy associated with mononucleosis is due to the suppressor T-cell activity, which acts to halt the proliferation of the stimulated B-cell. Mononucleosis is really a lymphoma which undergoes spontaneous remission because of this T-cell activity.

Hydantoin derivatives, like Dilantin, also appear to suppress T-cell production, and may account for

the 4x increased incidence of lymphoma in patients taking these drugs.

New studies are in progress in an attempt to understand this suppressor T-cell defect, with the hope of using this information in the treatment of lymphomas. There are many factors which decrease the T-cell response, among which are nutritional deficiencies that produce profound changes in the function of the immune system in man. The thymus is reduced in size and may undergo involution with marked changes affecting the cortex to a greater degree than the medulla. In animal experiments, leucine was the one amino acid whose deficiency resulted in depression of the immune system. These changes might be lumped together and be named "nutritional thymectomy."

Dr. Robert A. Good, of the Sloan-Kettering Institute, has stated: "For cancer to occur and persist, there must be a failure of the immunologic process. We have never found a cancer patient in whom something wasn't screwed up immunologically."

The following malignancies are considered to be oncogenic or viral-caused, at least in part:

1. Verruca condyloma
2. Laryngeal papilloma
Herpes Type II
3. Cervical carcinoma
Herpes Type II
4. Post-mumps testicular malignancy
5. Burkitt's lymphoma
6. Hodgkin's disease, following mononucleosis
7. Reticular cell sarcoma
8. Kaposi cell sarcoma
9. Osteosarcoma
10. Melanoma

In cervical carcinoma and laryngeal papilloma associated with

Presented before the Section on Allergy and Immunology, Indiana State Medical Association, Indianapolis, Oct. 7, 1974.

Herpes Type II, viral DNA is found in the cervical cells and in the papilloma cells, respectively. In many of these conditions antibodies are found in both the patient's serum and in the serum of the immediate family. It is also of interest that in the patients with far-advanced disease or widespread metastasis, no antibodies were found. These malignancies, which are probably viral-caused, show cross-immunity, whereas the malignancies which are produced by chemical or physical carcinogens produce specific chromosome changes, in which case the new antigens do not cross-react with each other and are specific in character.⁷

Factors in Growth of Neoplasms

1. Insufficient antibody is produced.
2. There is a blocking antibody which prevents the cytotoxic effect of the cellular antibody.
3. The tumor may be of such size that the immune mechanism is overwhelmed by the actual number of malignant cells.
4. The malignancy may be in a so-called "privileged site," where it is unable to bring the surveillance mechanism into effect.

Transfer Factor

Transfer Factor (TF) was discovered over 20 years ago by Lawrence,⁸ and was found to convert negative tuberculin reactors to a positive state. Transfer Factor is a preparation from human leukocytes, a dialysable substance which is considered to be a peptide-polynucleotide complex, a double-strand RNA with a molecular weight of about 10,000. This substance retains its potency for about five years and can be lyophilized and reconstituted, when needed, with water.

Since this substance was of value in treatment of both hereditary and acquired immune-deficient patients, it was decided to try T.F. in treatment of malignancies, and therefore restore the delayed hypersensitivity which had been lost by the patient. T.F. from relatives of patients who

had osteogenic sarcoma appeared to be of help in treatment of the sarcomas and restored the delayed hypersensitivity which had been lost. This substance is not antigenic, does not produce any antibodies, and also acts both as a general and specific stimulus to restore delayed hypersensitivity. Side effects are minimal, and when this substance is given to the normal patient, there is no reaction other than an occasional local type of response. Recently, at the Sloan-Kettering Institute, pooled T.F. was used for treatment of inflammatory breast cancer, and the material was given three times weekly for a period of one year. It was found that if specific T.F. was prepared from a donor who showed in vitro a response to tumor cells, there was a "killer" effect. That is, the T.F. acts to restore "remembrance of things past" to an otherwise negative-responding recipient.

The mono-specific T.F. is prepared by incubating the sensitive donor lymphocytes with tumor cells before the T.F. is extracted. The negative recipient who receives the T.F. will now reveal, in vivo and in vitro, a positive response. Interesting results were noted in treatment of osteogenic sarcoma, which has a 5% survival rate in five years, and only a spontaneous remission of less than 1%. The sarcoma is excised surgically so as to reduce the antigen load. In using the colony inhibition test, it was noted that 2% of normal patients showed an ability to inhibit the growth of the malignant cells, whereas 25% of household contacts of the patient had a positive response. One problem which arose was that the donor, after submitting himself to numerous venesections, no longer had the proper amount of T.F. to be of value. In other words, he had used up all of his T-cells. This, however, was restored to normal if he did not submit to venesections for a three-month period. Results were obtained in the presence of only one lesion or of a single metastasis. Similar results were noted in the treatment of hypernephroma.

Neuraminidase

Neuraminidase is an enzyme present in the protein coat of viruses and bacteria.⁹ A specific measurable cell-mediated cytotoxicity can be induced against certain advanced active cancers with the use of a vaccine made from the patient's own tumor cells and cholera vibrio neuraminidase. The action of the neuraminidase is to remove the protective sialic acid layer of the cells; therefore, the antigenicity of the tumor cells is increased.

The immune reactions of patients can be followed while immunotherapy is given in six monthly injections by the use of a specific in-vitro technic that uses the patient's own excised cancer tissue. Serum and lymphocytes from these patients show that lymphocyte cytotoxicity had been induced without any increase in the blocking antibody effect of the patient's own serum which could have enhanced tumor growth. The patient's tumor cells showed striking changes when they were subjected to the cholera vibrio neuraminidase. The tumor cells developed pseudopods and appeared to be held together by a stringy material, and the release of neuraminic acid into the incubating fluid was considered evidence that the cells had been exposed to this enzyme. The following tumors were studied: breast cancers, melanomas, ovarian, gastrointestinal, uterine, head and neck tumors, as well as sarcomas.

Rosette Test

An interesting phenomenon is the so-called Rosette Test. This is based on the fact that the T-lymphocytes will bind sheep RBC and produce a rosette formation. The prognosis is poor as to metastasis of any type of malignancy if there are no rosettes produced. It has been noted that after Transfer Factor is given, rosettes will appear, but soon wear off and will require repeated injections of this factor. Therapy that suppresses thymus function, including irradiation and cytotoxic drugs, such as azathioprine and nitrogen mustard, which are used to treat

malignancies, fortunately have a greater effect on the malignant cell than on the host cell. However, the host immune system recovers rapidly.

Thymosin

The hormone of the thymus gland was discovered in 1966 by White and Goldstein,¹⁰ and was called thymosin. This hormone was present in the serum and appeared to decrease when the animal or patient aged. The number of T-cells does not decline with the aging process; however, the mitogenic response—that is, the response to non-specific mitogens—is considerably reduced. This is chemically a polypeptide with a molecular weight of 12,000. It has the action of maturing the T-cells and increasing the response of B-cells to the T-cell antigens. It has been found to cause rejection of tumors in murine sarcomas. It also causes acceleration of the regeneration of lymphoid tissue after whole body irradiation, and the animal is thus able to tolerate larger doses of x-ray therapy.

A thymosin antiserum has been developed which has been found effective in treatment of various autoimmune diseases. These include system L.E., glomerulonephritis, myasthenia gravis and Goodpasture's syndrome. Of more practical importance, however, is the evidence that links aging to a significant decrease in the blood level of thymosin. This occurs in normal patients between the ages of 25 and 45. Goldstein has been able to assay the circulation of thymosin in the blood of both man and animals, using the Rosette bioassay and radioimmunoassay for presence of thymosin. He postulated that thymosin acts on stem cells that may have previously migrated from the bone marrow to the thymus gland. The rapidity with which the hormone can convert a stem cell to a T-cell perhaps suggests that thymosin may act to derepress, or to activate a cell already programmed to act as a T-cell.

Active Immunity

Cancers in laboratory animals

have been treated effectively with vaccines composed of live tumor cells. Since these could possibly cause neoplastic growth at the inoculation site, the tumor cells in human vaccines usually are inactivated by one of the following methods: irradiation, mitomycin-C, heat, or freezing and thawing. At New York's Memorial Hospital and at the Hospital for Special Surgery, osteosarcoma patients have been treated after amputation with vaccines prepared from irradiated lysed tumor cells. A preliminary report by Marcove indicates that half the patients who had received the vaccine are alive and well up to six years after surgery.

Passive Immunity

There are several medical centers that now administer passive immunotherapy by removing, reacting and then returning the patient's lymphocytes. A remarkable invention by an IBM engineer who lost his child with leukemia consists of a method of selecting cells on the basis of their weight and density. In a period of four hours, 100 million lymphocytes can be removed. The procedure does not damage the cells or cause hemolysis, and only 220 cc of blood is outside the body at any one time. In vitro, the lymphocytes are sensitized to human cells or activated by exposure to phytohemagglutinins before they are reinfused. Lymphocytes from recovered cancer patients or histocompatible siblings, who may be sensitized to the same carcinogen that produced the patient's malignancy, have also been used.

At the City of Hope Hospital it has been reported that several patients with advanced cancer received transplants of thoracic duct lymphocytes from histocompatible siblings, and a remission was obtained for at least six months. However, withdrawing these lymphocytes by placing a cannula in the thoracic duct is no easy task.

The Importance of Humoral Factors

Humoral factors were first demonstrated by the Hellstromms¹¹

of the University of Washington, who found a substance in the sera of patients which blocked the ability of lymphocytes to attack malignant cells. This blocking factor is an antigen-antibody complex. Also, an unblocking factor was found in the sera of patients who have had spontaneous remissions or regressions of breast and colon tumors.

By serendipity, it was also noted that healthy black donors have anti-blocking sera which can be used in treating patients with malignant melanoma.

Recently, Pilch has developed a new method for immunotherapy, which consists of a preparation of immune RNA to transfer immunity that is specifically directed against the tumor. This immune RNA is prepared by repeatedly inoculating an animal with tumor cells, or a soluble extract of a tumor, which contains transplantation antigens specific to that tumor. After several challenges are made and the animal becomes hyperimmune to the tumor, it is sacrificed and lymphoid tissues are removed. The RNA is extracted from the lymphoid cells by using hot phenol. The lymphoid cells extracted have somehow processed the tumor antigens and have synthesized an RNA which carries the message that confers tumor-specific immunity to the lymphocytes of the patient who has a tumor of the same histologic type. This immune RNA can be incubated in vitro with the patient's lymphocytes and then injected directly into the patient, or the immune RNA can be injected alone, and either will convert the patient's lymphocytes to act as killer cells against the tumor cells.

In another experiment planned, lymphocytes from melanoma patients who have good immune response in vitro to their own lymphocytes, and have positive skin tests to melanoma antigens, will be used to produce immune RNA, and then will be injected into melanoma patients who have poor immune responses. It is hoped that the response will be the same as with the use of Transfer Factor. If success-

ful, this will probably prove that human cancers are caused by viruses, because human tumors of a given histologic type cross-react in the same way that virus-induced tumors do in animals. The problem always is that large tumor masses of 10^6 tumor cells will not be helped with this form of therapy. The ideal patient for treatment by this method would be one with minimal amounts of residual tumor, or one with no clinically detectable disease, but who has a high probability of recurrence or metastasis because of the nature of the malignancy.¹²

It has been observed that a patient who has had a breast malignancy with as many as 20 positive lymph nodes and has been treated by mastectomy probably has some malignant cells left. The advantages of using immune RNA are that it is produced in animals, it is non-toxic, contains no transplantation immunogens since it contains no transplantation antigens, and it produces no graft-versus-host reaction.

The Importance of Cell Biology Studies

The cell membrane, which is one-half-millionth of an inch thin, is composed of proteins, lipids and sugar polymers which regulate multiplication and specialization of the cells. Studies are presently in progress regarding the sugar polymers, which make up only 3% of the membrane's composition, but are chemically coated to provide a system of cell recognition. If embryonic kidney cells and embryonic liver cells are mixed in a nutrient medium, they will creep along the plate and sort themselves out into proper grouping. If there is some defect in the composition of the cell membrane, this may play a role in metastasis.

In use at the Salk Institute is an extract of the wild castor bean,

which contains lectin that binds to sugars. The binding is accompanied by an electron-dense marker technique which will allow investigators to map the location of each lectin molecule on the cell membrane. It has been found that the sugars are widely dispersed over normal cell membranes, but cluster markedly in cancerous cell membranes. Also, the amount of sugar residues rises in the infected cells. In addition, some malignant cells swallow, or absorb, their membranes and replace them with a new surface, and therefore change the antigen activity.

BCG

It was accidentally discovered that BCG stimulates cancer defenses by acting non-specifically to restore the immune memory of lymphocytes. At Roswell Park Memorial Institute Klein¹³ has used BCG in treatment of skin cancer and has reported some success with its use in breast cancer. In France, BCG has been combined with tumor cell implants in experimental treatment of acute lymphoblastic leukemia.¹⁴ There is also some evidence that BCG may play a preventive role in building up immunologic resistance in general.¹⁵ In Chicago, a study of two large groups of children, one vaccinated at birth with BCG, and the other used as controls, revealed that the controls developed leukemia at a rate seven times higher than the injected patients.

To quote Sir Peter B. Medawar, Nobel laureate, "In the next 10 or 15 years we have every reason to expect profoundly important advances in the treatment of cancer and in the management of immune deficiencies and autoimmune disease."

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Copies of the 1975 Roster and Yearbook are available at the office of THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208. Price: Yearbook (June issue): \$10.00; Roster: \$5.00 each. Please send check with order.

What's New?

Knoll Pharmaceutical announces improvements in the formulation of Dilaudid. Tablets will be color-coded to distinguish the 1-2-3-4 milligram sizes. The tablets will also be larger and easier to handle, will be inscribed with the potency and will bear the Knoll logo.

* * *

Orthopedic Equipment of Bourbon has a new arm sling called "Slinger." It is made in three sizes (S,M,L) and in three styles: patchwork denim, light blue and black. Each style is made with a metal slide adjustment in the back and a Velcro® adjustment closure in the front.

* * *

Air Products has a new Foregger® brand disposable humidifier. The humidifier delivers 91% relative humidity at a flow rate of four liters per minute. An evaluation program booklet is available for use of respiratory therapists.

* * *

Unirad has a new echocardiography system which features centrally located and special function-oriented controls, a large oscilloscope display screen and ease of mobility. It has two display modalities, one for image viewing and one for producing hardcopy records.

* * *

John Wiley & Sons have released NATIONAL HEALTH INSURANCE: CAN WE LEARN FROM CANADA? It is a compilation of the findings of 39 health policy experts from the U.S. and Canada. 273 pages, \$10.95.

* * *

Sandoz has a new brochure "Growing Toward a Better Life," for distribution by doctors to their patients. It contains helpful ideas about social and volunteer activities, in addition to advice about diet, exercise, medical care and mental health, especially as this advice applies to the elderly.

* * *

Astra is making a new dosage form of its bronchodilator, Bricanyl® (terbutaline) Sulfate. The new product will be Bricanyl Sulfate Tablets, in 5 mg and 2.5 mg sizes, the smaller size intended chiefly for children, but not recommended for children under 12 years of age.

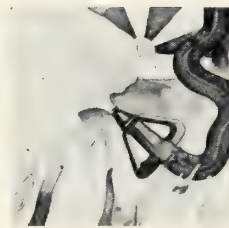
* * *

International Biophysics Corporation announces the adaptation of a biomedical polymer to an electrode system which makes it possible to monitor continuously a patient's pH during and after major surgery. A dual sensor, which will monitor both pH and PO₂, will be marketed under the trade name pHoxytrode™.

* * *

Control-o-fax Office Systems has a new simplified insurance claim processing method for medical offices. It is designed to reduce insurance paperwork and speed up carrier handling, while improving cash flow. All treatment and payment information is entered on the form during the patient's visit—no need to go back over patient records to complete insurance forms.

* * *



Pro-Banthine®

brand of
propantheline bromide

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control.

For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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San Juan, Puerto Rico 00936

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Medical Department, Box 5110, Chicago, Ill. 60680 481

"Antiacid" action for ulcer patients...

one of the many things you need in an anticholinergic.



Pro-Banthine is considered adjunctive in total peptic ulcer therapy that may include diet, conventional antacids, bed rest, and other supportive measures.

Pro-Banthine is provided in several different dosage forms which will meet virtually any clinical need. It is just as versatile in filling patient needs, among which are:

"Antiacid" action — Pro-Banthine® (propantheline bromide) reduces gastric secretory volume and resting total and free acid.

"Analgesic" action — Pro-Banthine helps to control the acid-spasm-pain complex.

Vigorous anticholinergic action — Pro-Banthine® Vials, 30 mg., are for intramuscular or intravenous use when prompt and vigorous anticholinergic action is required.

Mild anticholinergic action — Pro-Banthine® Half Strength, 7.5 mg. tablets, for more exact adjustment of maintenance dosage in mild to moderate gastrointestinal disorders.

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option
in peptic
ulcer**

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Each capsule contains 50 mg.
of Dyrenium[®] (brand of triamterene)
and 25 mg. of hydrochlorothiazide.



For long-term control of hypertension*

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

*

WARNING

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

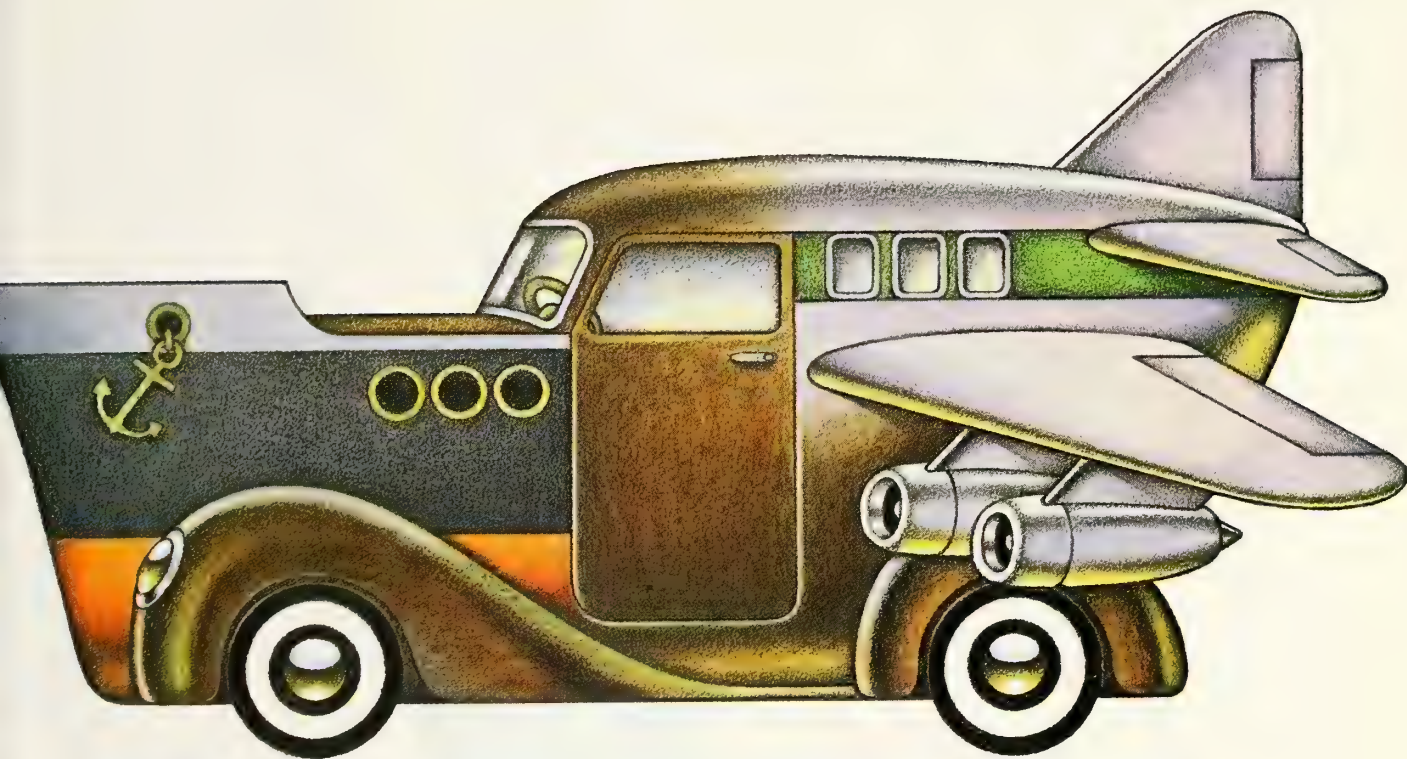
Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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'DYAZIDE'

Just once or twice daily for maintenance.
Hydrochlorothiazide to help keep
blood pressure down and triamterene
to help keep potassium levels up.



On land, sea, and in the air...

Up to 24 hours of effective control with a single dose...in nausea, vomiting and dizziness associated with motion sickness.

Dosage: 25 to 50 mg. 1 hour before travel.

Available on prescription only.

BRIEF SUMMARY OF PRESCRIBING INFORMATION
CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did

not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

ROERIG *Pfizer*
 A division of Pfizer Pharmaceuticals
 New York, New York 10017

Antivert®/25 Chewable Tablets
(meclizine HCl) 25 mg.
for motion sickness

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association



The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

Opinion
&
Dialogue

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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Carcinosarcoma of the Urinary Bladder—A Case Report

LEO J. McCARTHY, M.D.,
WILLIAM M. WAHLE, M.D.,
NEALE A. MOOSEY, M.D.
Indianapolis

Introduction

THE limited experience with bladder neoplasma composed of both malignant epithelial and stromal elements makes prognostication difficult. The confusing nomenclature which has been used in referring to these rare neoplasms lends difficulty to literature review.¹⁻¹³ Controversy of their histogenesis had led to theories ranging from fortuitous development of two autonomous neoplasms in contiguous areas, "collision tumors," to malignant changes occurring simultaneously in the bladder urothelium and in the bladder stromal tissues, a "composition tumor."⁵

Pure "one sided" sarcomatous development of stromal "stem cells" apparently can result in pure bony, pure cartilaginous, or pure muscular sarcomas, or a composite mixture of sarcomatous elements.^{4,6,9-13} An additional case report is presented to add to the small number of reported cases.

Case Report

A 77-year-old black woman was admitted to the hospital complaining of a painful stasis ulcer on her left leg. She had been followed as an outpatient with hypertensive cardiovascular disease without significant urinary tract symptomatology. During hospitalization spontaneous painless gross hematuria occurred. Cystoscopy revealed a large polypoid mass arising from near the right ureteral orifice. A cystogram demonstrated a large (6 cm) tumor occupying right posterior wall of the bladder. A segmental cystectomy and right ureteral neocystectomy were performed.

The surgical specimen consisted of a 62 gm, 5 x 4 x 4 cm

mass of tissue, one portion covered by mucosa. There was a 5 cm bulky white fibrous neoplasm arising immediately beneath the mucosa. This appeared partially circumscribed. Microscopic examination revealed a malignant neoplasm composed of plump spindle shaped cells with abundant mitosis often arranged in a herringbone pattern. Several multinucleated tumor giant cells (Fig. 1) were present as well as areas of immature osteoid and mature and immature cartilage, together with focal areas of adenocarcinoma. The Armed Forces Institute of Pathology, (GU and Soft Tissue Branches) concurred with diagnosis of carcinosarcoma.

The immediate postoperative course was uneventful and the patient was discharged on antibiotics, to be followed as an outpatient. The patient did not desire further sur-

gery. One month after discharge, because of hematuria, direct bladder visualization was attempted. However, a cystoscope could not be passed. A large, hard, fixed and ill-defined mass which was previously not present was palpated within the right pelvis. The previous surgical incision was indurated and quite tender. She was readmitted, and chemotherapy, 5 FU and Oncovin was begun 3 days after admission. She expired eight days after admission. The postmortem examination was restricted to the abdomen and performed four hours after death. Inspection through the midline incision revealed numerous gray-white metastatic tumor nodules on the serosa and in the muscular wall of both the small and large bowel, the largest 2.5 cm in diameter. (Fig. 2) Several similar nodules were found within the mesentery. Just su-

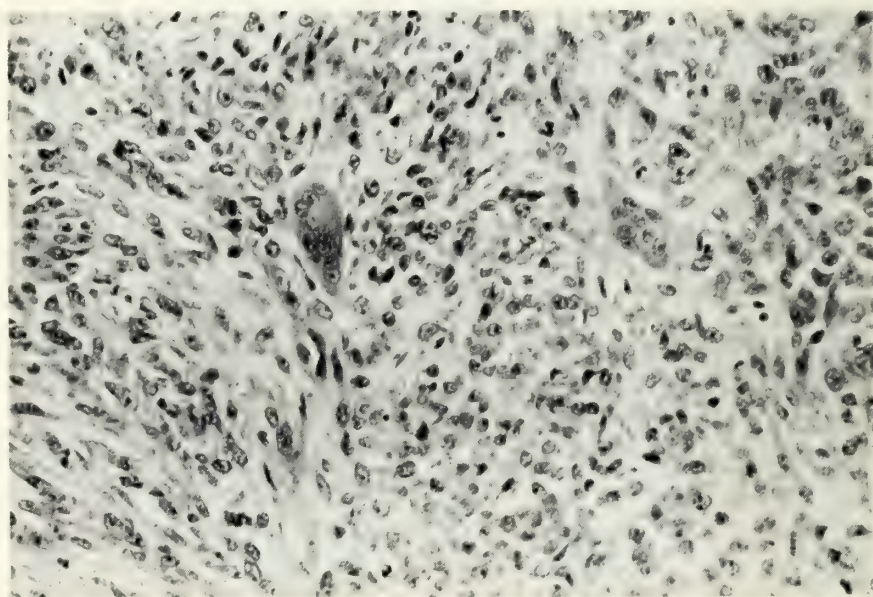


FIGURE 1
Numerous bizarre tumor giant cells scattered in sarcomatous immature stromal background. Hematoxylin-eosin, original magnification 80x.



FIGURE 2
Numerous serosal
tumor implants on
small bowel.

ence of metastatic lesions within the bowel serosa and muscular wall suggests evidence for the local implantation, lymphatic and/or hematogenous spread of this tumor. The usual behavior of these neoplasms is that of a locally aggressive⁴ malignant neoplasm, which this case also illustrates.

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perior to the symphysis pubis, in the area of the recent surgical incision and involving the rectus muscle, a discrete 3.5 cm variegated fleshy tumor was found.

There was a 4 x 2 x 1 cm polypoid sessile neoplasm with a roughened shaggy mucosal surface arising from the right posterior bladder wall. (Fig. 3) Immediately adjacent to this bladder mass was a large, fixed, ill-defined, approximately 8 x 5 cm tumor within the right side of the pelvis which was densely adherent to the rectum. Tumor implants were present on the serosa of the uterus on the right. The liver, adrenals and ovaries were free of metastatic neoplasm, as was the uterus. The histology of these tumor implants and bladder recurrence were similar to the original bladder neoplasm.

Summary

An additional case report of carcinosarcoma is presented. The pres-

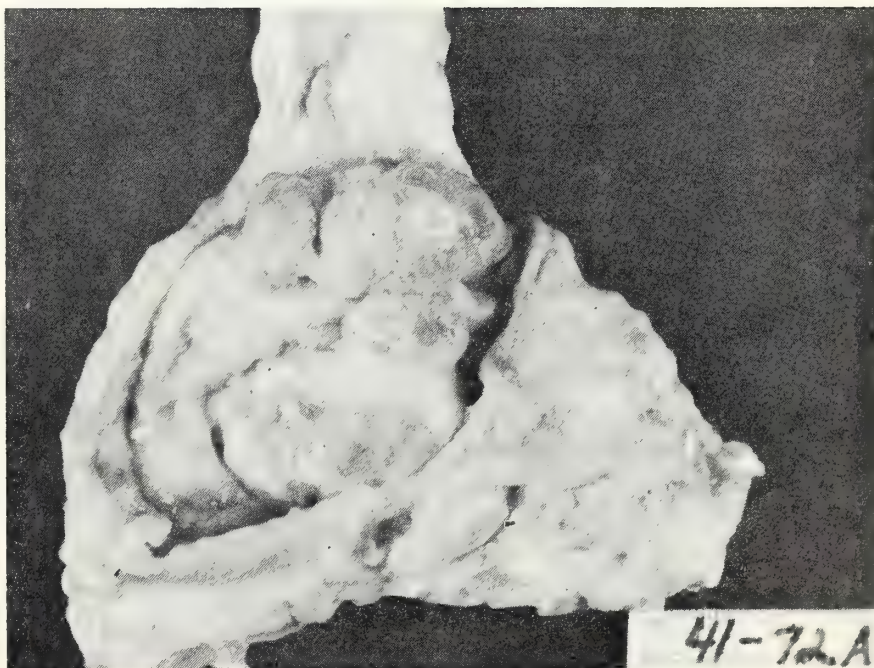


FIGURE 3
Autopsy specimen of bladder showing infiltration of the submucosal neoplasm through the bladder wall.

- sarcoma of the bladder: Report of unusual simultaneous occurrence of both tumors. *J. Urol.* 59:1121-1126, 1948.
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★

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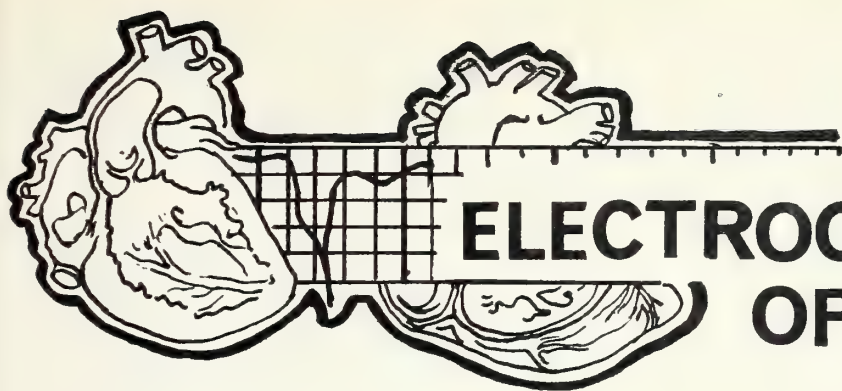
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ELECTROCARDIOGRAM OF THE MONTH

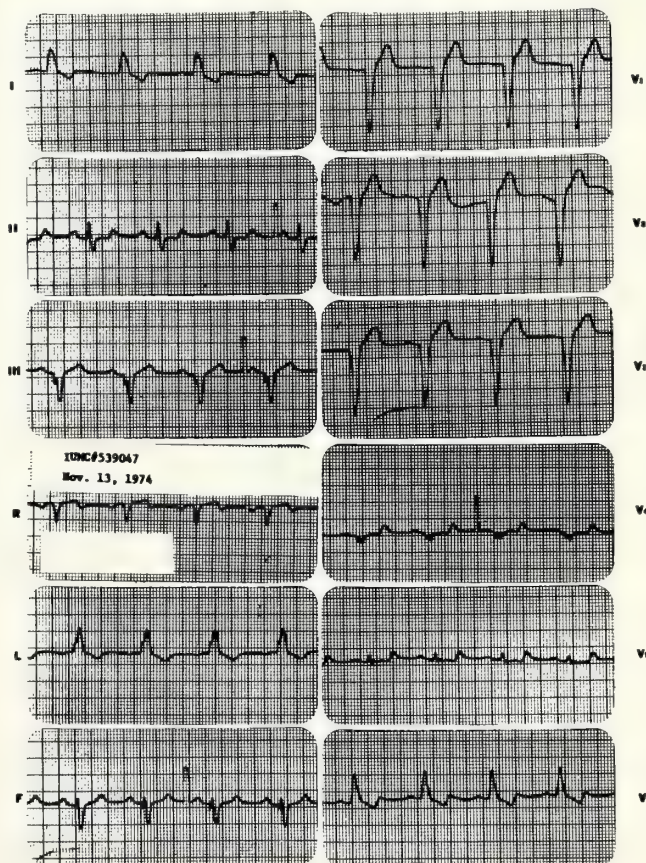
Left Bundle Branch Block

JOHN C. BAILEY, M.D.
Indianapolis

THE muscle mass of the left ventricle is considerably greater than that of the right ventricle. Therefore left ventricular electrical depolarization accounts for the most part of the normal QRS complex. Conduction block in the left bundle branch results in anomalous activation of the left ventricle. Consequently, the entire QRS complex is distorted by complete left bundle branch block. This is in contrast to right bundle branch block, in which only the terminal portion of the QRS complex is abnormal (see ECG of the Month, *JISMA* July 1975). The electrocardiographic features of left bundle branch block are (1) a QRS duration of 0.12 sec. or greater, (2) absence of septal q waves in leads I, aVL, and the lateral precordial leads, (3) a slurred R wave in leads I and V₆, and (4) small r and broad S waves or qS waves in the right precordial leads. These criteria are present in the tracing under discussion. Note the qS complexes in V₁ - V₃ and the broad q in V₄ that, in the absence of complete left bundle branch block, would indicate anterior wall myocardial infarction. However, because of anomalous activation of the left ventricle in left bundle branch

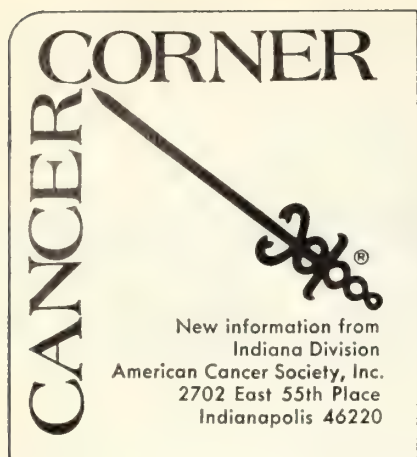
block, the QRS changes of myocardial infarction are obscured. Thus, for practical purposes, the electrocardiographic diagnosis of infarction in the presence of this conduction disturbance cannot be

made. Complete left bundle branch block nearly always indicates the presence of organic heart disease, most commonly arteriosclerotic or hypertensive or the combination of the two diseases. ◀



Complete left bundle branch block.

From the Krannert Institute of Cardiology, Marion County General Hospital, and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.



SECOND ANNUAL CANCER SYMPOSIUM FOR THE PRIMARY CARE PHYSICIAN

When: Oct. 1, 2, 3, and 4
Where: Inn of the Four Winds
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Smithville, Indiana

Two nationally recognized speakers will participate in the Second Annual Cancer Symposium for the Primary Care Physician—Dr. Elisabeth Kubler-Ross and Mrs. Helene Brown.

Dr. Ross is a well-known speaker and author of *On Death and Dying*, *Questions and Answers to Death and Dying*, and a recent publication *Death, the Final Stage of Growth*. On Thur., Oct. 2, she will address the Conference from 11 a.m. to 1 p.m.—“DDT (the Doctor's Dilemma—Thanatology).” In the evening from 7-9 p.m. Dr. Ross will lead a two-hour open discussion on “The Frustrations and Joys of Death.”

Born in Switzerland, Dr. Ross received her M.D. from the University of Zurich in 1957. Her experience began as a country doctor; she continues to demonstrate a humane approach to relieving the psycholog-

ical suffering of the terminally ill in a world where advanced technology and science often work to depersonalize the patient.

Dr. Ross comments about her studies in death and dying, “It is hoped that it will encourage others not to shy away from the ‘hopelessly’ sick but to get closer to them, as they can help them much during their final hours. The few who can do this will also discover that it will be a mutually gratifying experience and they will learn much about the functioning of the human mind, the unique human aspects of our existence, and will emerge from it enriched and perhaps with fewer anxieties about their own finality.”

* * *

Mrs. Helene G. Brown is a noted authority recognized by the American Cancer Society for her long-time interest and expertise in the problems associated with efforts to control use of unproven cancer remedies. On Friday, Oct. 3, she will discuss, “Cancer Quackery—A Cruel Hoax” from 11:30 a.m. to 1 p.m.

She has been an enthusiastic member of the National American Cancer Society Committee on Unproven Methods since 1964. Since 1955, the Society has had a committee on unproven methods of cancer management which serves as a central coordinating force in this field.

At present Mrs. Brown is public health commissioner in Los Angeles County, Calif., and executive director of the Los Angeles Council of The National Voluntary Health Agencies. Demonstrating an active interest in the fight against cancer, she has functioned in a variety of responsibilities with the California ACS and with the national organization. In her state she is chairman of the Board of Directors and also serves on the national Board of Directors.

* * *

Topics and speakers include:
LYMPHANGIOGRAPHY—1975,
Patrick A. Dolan, M.D.
MANAGEMENT OF RECURRENT
ENDOMETRIAL CARCINOMA—Clarence E. Ehrlich, M.D.

CEA-USES AND MISUSES—Ross McKenzie, M.D.

DIAGNOSIS AND TREATMENT OF METASTATIC CERVICAL NODES WITH UNKNOWN PRIMARY CANCER—James E. Schroeder, M.D.

NEWER CONCEPTS IN THE DIAGNOSIS AND MANAGEMENT OF DIC WITH SPECIAL REFERENCE TO MALIGNANT DISEASE—Nils Bang, M.D.

THE LABORATORY DIAGNOSIS OF MULTIPLE MYELOMA—David E. Smith, M.D.

DIAGNOSIS AND MANAGEMENT OF COMMON SKIN CANCERS—William B. Moores, M.D.
THE TREATMENT OF MULTIPLE MYELOMA AND CHRONIC LEUKEMIA—Laurence H. Bates, M.D.

THE SEQUENCE OF PALLIATION OF METASTATIC BREAST CARCINOMA—William M. Dugan, Jr., M.D.

THE TREATMENT OF HODGKIN'S AND NON-HODGKIN'S LYMPHOMA—Lawrence H. Einhorn, M.D.

CANCER SUPPORT SYSTEMS—Donna J. Minnick

NEW DIAGNOSTIC APPROACHES TO LUNG CANCER—David Brown, M.D.

PRE-TREATMENT EVALUATION OF LUNG CARCINOMA—A SURGEON'S VIEW—Harold Halbrook, M.D.

USES OF RADIOPHARMACEUTICALS IN CANCER—Eugene D. VanHove, M.D.

NEW THERAPEUTIC APPROACHES TO OAT CELL CARCINOMA OF THE LUNG—Lawrence H. Einhorn, M.D.

* * *

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Guest Editorial

Medicare and Diagnosis

EVERY doctor knows that the practice of medicine daily becomes more complicated. Now Medicare has informed us that there must be a diagnosis to support each test done on the patient. On the surface, this is a reasonable bureaucratic request—and usually not too difficult. “Congestive heart failure” (427.0) or “Acute bronchitis” (466) will support a chest x-ray. Even “chest wall pain” (355.1) will support an electrocardiogram. But what does one do with the T4 on the somewhat pudgy Greek lady who never learned to speak English? Or what is an on-the-spot diagnosis for the late Friday “drop-in emergency” with a 14 year history which make MacBryde’s “Signs and Symptoms” look like a condensed version?

We have a colleague who uses “Possible internal disease” (796.9) for a Pap smear, but this seems a bit elusive and makes the patient more uneasy than the procedure. Maybe one could confuse the clerk in the Medicare office by using some of those diagnoses they’ve never seen before, like “Sucked into a jet” (E844) or “Healthy person accompanying sick relative” (Y08). Perhaps on some Saturday afternoon if one went through the whole book one could compile a quick

reference list of a few medical entities which could support most common laboratory tests.

In the long run it would be better to be honest, but I can’t find the correct diagnosis in the I.C.D.A. The book does not list “Muddled thinking,” “Diagnostic hunch which didn’t pan out,” “Bum steer,” “Red herring,” or “Diagnostic dilemma.” Does anyone know how you go about getting new diagnoses in the book?—**G. A. Diettert, M.D., Missoula, Mont.,** Rocky Mountain Medical Journal, May 1975.

Editorial Notes . . .

Research now indicates the possibility that glucagon malfunction, in addition to insulin malfunction, may be the basic cause of diabetes. Roger Unger of the VA Hospital in Dallas has received the Banting Medal and the David Rumbough Jr. Memorial Award for his work on glucagon. A means of suppressing glucagon may prove to be a major step in treating or preventing diabetes.

Senate Act 264, enacted by Indiana’s 1975 legislature, permits courts to accept electronically processed data as evidence. It states that medical data on a computer printout “shall be treated as original records in all courts or administra-

tive agencies for the purpose of its admissibility into evidence.” Four provisions must be met to authenticate computer records for use in court: 1) the data processing system must be standard equipment in the hospital, 2) entries must be made close to the actual time of occurrence, 3) the information must be properly safeguarded from unauthorized use, and 4) records must be maintained showing all original entries and the subsequent access to those entries.

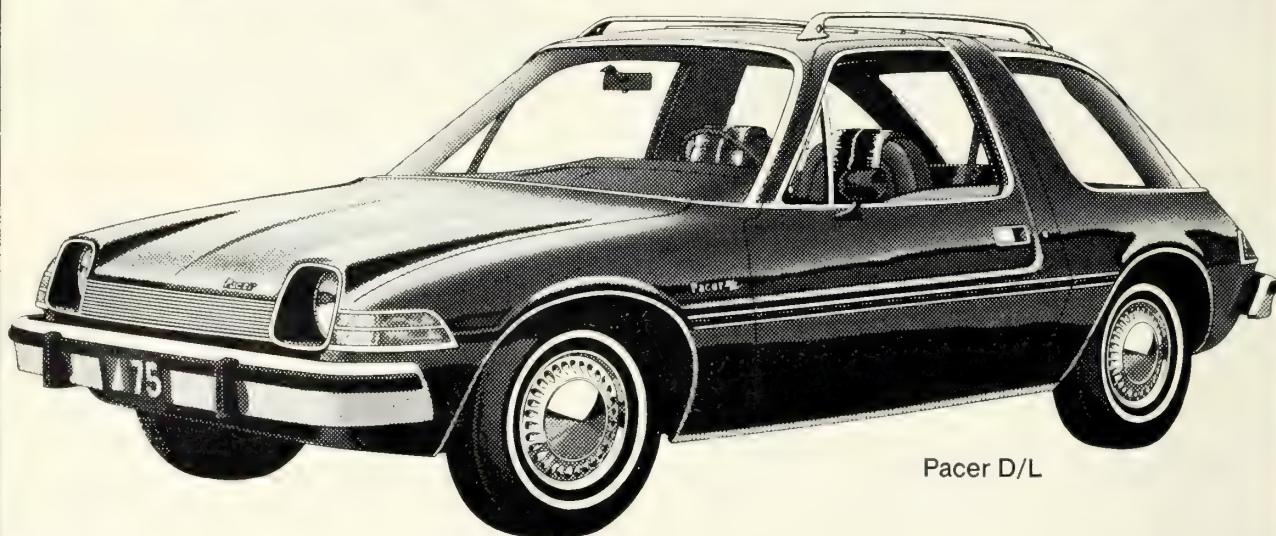
FDA Commissioner Alexander Schmidt, M.D., is seeking legislative approval for the granting of limited marketing approval to certain drugs to facilitate the monitoring of drug use, misuse and adverse reactions. He thinks this approval process should extend to at least the first two or three years of drug marketing.

The American College of Radiology reports that a survey participated in by 13,278 of its members showed that 64% of the respondents are billing patients separately for professional services. This total includes an estimated 3,300 groups and about 6,500 hospitals. The majority of radiologists work in private offices and are also affiliated with hospitals. ◀

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ABSTRACTS, BOOK REVIEWS

DERMATOLOGY (THIRD EDITION) DIAGNOSIS AND TREATMENT OF CUTANEOUS DISORDERS

William D. Stewart, M.D., Julius L. Danto, M.D., Stuart Maddin, M.D., C. V. Mosby Co., St. Louis, 1975; 537 pages; 40 chapters; 57 color plates; \$22.50.

The two previous editions of the text were entitled "Synopsis of Dermatology." With this edition the term synopsis no longer applies. Such is noted just from the increase in the number of pages and the addition of the number of items applicable to dermatology.

The increase in the number of pages is well worthwhile. None of them is just a fill-in. They all contain real meat, thus justifying expansion in a very genuine way. The second edition preceded this by four years; thus, sufficient time has passed for the introduction of many new aspects, views and findings into dermatological discoveries and changes in regard to the many facets of cutaneous fields.

The book is well written and edited. The paragraphs headed "Natural Course" and "Pertinent Information" have again been incorporated, as in the previous editions. Again, it can be stated that they have been of much aid in having patients read the appropriate paragraphs, thus getting a summary and answers to questions arising in their minds.

This edition will be greatly appreciated by all individuals interested in dermatology, whether G. P., family physician or specialists. Sufficient suggestions are made for treatment of the various conditions in quite an orderly fashion.

An added feature which is noted in the preface is the listing of text books, monographs and pertinent papers at the end of major headings, thus giving the reader very ready references.

Another notation made in the preface is the updating of the status of immunological cutaneous diseases (Chapter 7). This chapter especially should be read and thoroughly understood and digested by the general or family practitioner. Much misinformation would be averted and corrected.

Another notation in the preface is the semi-new form which has been recorded for regional diagnosis.

It is the opinion of the reviewer that the Third Edition can be considered to be a much larger and much improved text over the previous two editions. Much thought and hard work certainly have brought it to the excellent status it should enjoy. It is hoped the three collaborators enjoy long enough life and ambition to consider another edition in four years. Gradual enlargement of context and adding new features over the coming years will undoubtedly raise this book to full status as a bonafide textbook.

No more objections than those voiced in the previous review can be registered in regard to this edition.

Again, a statement from a previous review in regard to this text. "This book is a 'buy' for students, residents, generalists and the real dermatologists."

SAMUEL R. MERCER, M.D.
Fort Wayne

NEUROPSYCHIATRY IN WORLD WAR II

Medical Department, United States Army, Vol. II, Overseas Theatres, Edited by Albert J. Glass, M.C., U.S.A. (Ret.), Office of the Surgeon General, Department of the Army, Washington, D.C., 1973.

This volume is but one of 32 published by the U.S. Army Medical Department Historical Unit and they encompass all aspects of army medicine and surgery in the war. The first volume devoted to neuropsychiatry concerned the "Zone of Interior" and this second volume in the series concerns our military psychiatric efforts in various theatres of war, including the Mediterranean (formerly North African), European, Pacific and secondary areas of the conflict such as the Middle East and China-Burma-India. Separate chapters are devoted to the Army Air Forces, Prisoners of War and a summary. One psychiatrist representing various station and general hospitals was asked to write an individual history. Intervening narrative connections were written by the editors. This has created a panoramic view in one sense but some overlapping of background material.

This is a large volume and contains 1146 pages with 102 illustrations, 14 charts, 100 tables and 36 maps and a "comprehensive index"—as the accompanying letter to the reviewer has it. The purchase price is \$16.20, which seems quite low for so much. It is an interesting accumulation of fact, anecdotes, reminiscence and history, although the method of composition is loose and rambling. A commercial product would have shrunk under the editor's blue pencil.

Our military endeavors covered the globe from 1940 to 1946 and yet a similar pattern in all theatres of disregard for psychiatric problems was shown by the line officers. They always resisted designations such as "combat neurosis" and, in 1943, after a psychiatrist was formally placed on the division role, the only acceptable diagnosis was "exhaustion," which presumed a physical cause for mental breakdown. The knowledge gained by the AEF in France had been forgotten and had to be completely relearned. It was found that up to 80% of "exhaustion" cases could be returned to their front line units if treated in a forward hospital (often only a tent compound) which was safe but not entirely so, and remained, as it were, within earshot of the big guns. If the mental breakdown case was evacuated back to England or to Australia, the psychiatric patterns of rejection of the death-dealing front lines became fixed. Most of our psychotropic drugs were unavailable in the early 1940s but good use was made of intravenous barbiturates, hypnosis and electro-shock therapy.

Many sidelights of history are forthcoming in this book. The famous General Patton slapping incident is the archetypal instance of a line officer's inability to accept the tenet that "every man has his breaking point," which, of course, is the keystone of psychiatry. Good morale in the smaller units was vital in preventing mental breakdowns. Leadership and a winning cause kept the psycho-casualties to a minimum. An interesting fact is that previous neurosis in civilian life did not necessarily predispose the man to combat neurosis. An occasional soldier even enjoyed the "killing life."

I hope (and trust) that these medical military histories serve the useful purpose of causing the armed forces to learn from the mistakes of the past, because the cost of producing a complex book such as this and the 31 similar books is noteworthy. Nevertheless, this second book on psychiatry in World War II makes very interesting reading purely as history, and it is as an historical document that the effort should be judged. On the whole, I think it is worthwhile, but an industrious editor could shorten this volume considerably. Oh the munificence of our government!

RODNEY A. MANNION, M.D.
La Porte

THE HEALING HAND—MAN AND WOUND IN THE ANCIENT WORLD

Guido Majno, Harvard University Press, Cambridge, Mass., 1975; 571 pages lavishly illustrated with color plates and photographs; colossal bibliography; \$25.00.

Seldom does one come across a monograph that brings into vivid life the Age of Pericles! The catastrophies of anatomical ignorance side by side with masterpieces of surgical ingenuity; that trick of using large-jawed ants to hold the gaping lips of a wound; a rationale for the smearing of grease and honey on wounds, thus anticipating antisepsis; frankincense, myrrh, cinnamon and then drenching with wine; the map of the (then known circa 500 B.C.) world (p. 228) all dissected with loving care! The painstaking reader can read, re-read and ever learn more! Even the Chinese YANG and YIN, acupuncture; Hippocrates and Galen—all examined probingly and brought to vivid life!

Plastic surgery is reconstructed and we see illustrations of Sushruta's pedicle flap nose restorations (p. 292). Pliny is quoted at length (p. 342-on) anent "world and physics," "women and cosmetics," "food and wine," "superstition and magic," etc. Plate 9.2 facing p. 345 presents us with an excellent reproduction of a 14th Century manuscript edition of Celsus.

The binding and printing are superb; the paper of the best! All in all: congratulations all around!

ARNOLD LIEBERMAN, M.D.
New York City

CELL PATTERNING

Ciba Foundation Symposium No. 29 (New Series) held in London, 1974, S. Brenner, chairman; edited by Ruth Porter and John Rivers, Elsevier Press, New York City; 24 papers; 356 pages with charts, tables and illustrations; \$27.50.

This impeccably accoutered volume updates the consistently hard-to-answer question as to just *what* makes the single cell differentiate, develop and—eventually—become the total individual of that particular species. We do have an ever-clearer understanding of the chromosomes, their shapes and forms; we are getting down to the molecular basis; a precise chemical structure is being adumbrated but—just *what* makes those molecules unfold as they do? Just what makes one cell go on and form an insect and another cell develop a hominid?

Morphogenesis just *must* result from organized cell proliferation and spatial cell differentiation. Genetic mosaic experiments confirm the idea that genetic information is expressed within the cell itself. The cytodifferentiation genes somehow tie in with selector genes. Even elucidation of the precise chemistry just does not give us—as of 1975—the *raison d'être* of the ever-so-precise mechanism. Let us hope that in the near future some young investigator will come up with the Nobel prize-worthy answer.

As usual, the printing, binding and paper continue their maximal qualities. I failed to perceive any typographical errors. A most worthy accomplishment!

ARNOLD LIEBERMAN, M.D.
New York City

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DIAGNOSIS AND TREATMENT OF THYROID DISORDERS

Kenneth Sterling, M.D., CRC Press, Cleveland, 1975; 121 pages; 7x10-inch page size; \$26.95.

This new book on thyroid disorders is very timely and well received. With the development of newer technics, the thyroid diagnosis is becoming somewhat complicated. The author has successfully attempted to present the standard teaching along with modern developments in a simple and concise manner. Dr. Sterling is a clinical professor of medicine at Columbia University College of Physicians and Surgeons. He is a well known investigator in thyroidology and has made many original contributions. The chapters dealing with thyroxine production and turnover, T3 metabolism and TBG are best, as they contain the author's original work in these areas. Chapters dealing with treatment of thyroid are equally valuable, as they give us not only the conventional approach but also the author's personal experience over the last 20 years of practice. Discussion about thyroid nodules and cancer is practical and avoids lengthy histological classification details. Pleasant surprises were modern topics like T3 toxicosis, mechanism of hormone action, medullary carcinoma of thyroid, and pathogenesis of Hashimoto's thyroiditis and Grave's Disease. The book gives plenty of excellent references (total 450) for further reading.

This book is recommended as a valuable addition to every medical library and personal collection of medical students and physicians dealing with thyroid disorders.

SHAHID ATHAR, M.D.
Indianapolis

MTP INTERNATIONAL REVIEW OF SCIENCE—ENDOCRINE PHYSIOLOGY

Vol. 5, Physiology Series I, A. C. Guyton, consultant editor, S. M. McCann, volume editor, Butterworth and University Park Press, Baltimore, 1974; 10 chapters; 348 pages; \$19.50.

This volume is heralded as being a new concept in scientific publishing. The consulting editor (Professor A. C. Guyton) states flatly that every two years the individual author will update his stated topic, not just by making lists of annotated references, but by making a thoughtful and logical exposition of the material discovered in that time. In other words, the highly technical material being presented will be brought up to the minute every two years!

In my opinion, nothing can illustrate the impetuous pace of our progress in this (and other fields) than this conscious effort to bring the reader right up to date as frequently as just every two years.

This quite abstruse work in its narrow specialty illustrates our growing, ever-limiting specialization. Neurophysin, ADH (with its metabolism and actions), and the detailed approach to the hormones, the glands manufacturing them, cyclic AMP, etc., was terra incognita even five years ago. And yet, we are rushing headlong into discussions of Renin-angio-tension system, the exact physiological controls of oxytocin release, the exact stereochemistry of the responsible compounds, the precise interplay of the responsible ions—things undreamt of even a decade ago!

No wonder Dr. Guyton plans on total revisions every two years! These are volumes for the specialist by the specialist. The average M.D. or even the ordinary Ph.D. in Physiology, such as I, will not consume this fare! It is geared for the super-duper expert in his one most narrow and confining field. One can only hope that this growing backlog of knowledge will lead to practical applications—if not tomorrow, then the day after.

The binding, paper and printing are up to the expected

standards set by University Park Press. I saw no typographical errors. And—frankly—there was much that I failed to comprehend.

ARNOLD LIEBERMAN, M.D.
New York City

ACUPUNCTURE ANESTHESIA TEXTBOOK

International Acupuncture-Anesthesia Coordinating Group with Dr. Wei-Ping Loh, M.D., Century Medical Publications, Inc., 1974; 55 pages; properly illustrated with figures, tables and supplements, \$7.00.

There are 12 short chapters dealing with nervous system, physiology of neural involvement, psychology of pain, principles of acupuncture anesthesia, experiments in acupuncture anesthesia and other areas. The last half of the book contains discussions on biomedical instrumentation, key points for acupuncture anesthesia, pharmacology, dental acupuncture anesthesia, surgical technics and electrosleep therapy.

The presentations are orderly and concise. The illustrations are clear. The paper and printing are both of superior quality.

In view of the volume of the book, it is not really a textbook. It would be more properly called "Introduction to Acupuncture Anesthesia."

This small book is useful for basic understanding of acupuncture anesthesia and should be highly recommended for that purpose. The book may be directly purchased from the Century Medical Publications, Inc., P.O. Box 706, LaPorte, Ind. 46350.

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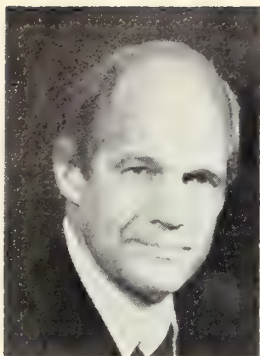
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ARNOLD H. KAMBLY, M.D.
Psychiatrist-Director



President's Page

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- * Provides a way for the members of the medical profession to unite and act on matters affecting the public health and the practice of medicine.
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- * Conducts an active public relations program by providing speakers for lay gatherings.
- * Represents the medical profession before the Indiana General Assembly and the United States Congress.
- * Keeps in touch with state and national agencies administering medical health welfare programs in order to offer them advice and cooperation: to present views of the medical profession on administrative policies and details.
- * Publishes **The Journal** of the Indiana State Medical Association, the first line of communication among physicians of Indiana and between the Indiana State Medical Association and its members.
- * Issues the **News Flash**.
- * Issues legislative bulletins to county medical society officers.
- * Makes postgraduate training programs available to all members by means of the annual meeting; cooperates with the Indiana Medical School and health agencies in similar projects.
- * Assists the State Board of Medical Registration and Examination in matters involving the administration and enforcement of the Indiana Medical Practice Act.
- * Supports and assists Indiana University School of Medicine and hospitals in maintaining a high standard of training for students, interns and residents.
- * Cooperates with the American Medical Association in promoting activities in providing services of value to the medical profession.
- * Maintains an executive office and building in Indianapolis, manned by a staff which devotes its full time to the interests of the medical profession.
- * Conducts and sponsors district and statewide conferences.
- * Maintains a speakers bureau to help county medical societies and other professional groups.
- * Maintains liaison with Indiana hospitals and with the hospital association, as well as other professional organizations.
- * Furnishes members with information about candidates for public office regarding their views on medical and health matters.
- * Maintains a physician's placement service—a service to both physicians and to communities.

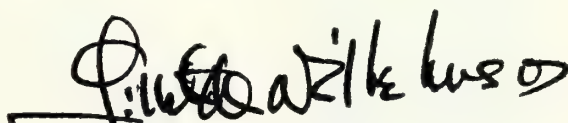
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- * Data on physicians. An alphabetical file of Indiana physicians is maintained at the Indianapolis office.
- * Hospital data. Information regarding Indiana hospitals and extended care facilities in nursing homes is available upon request. Also, material is available on hospital construction, medical staff organization and accreditation requirements.
- * Government medical care programs. The Association will represent you on matters pertaining to questions which may arise under Medicare, Medicaid, CHAMPUS, Crippled Children, V.A., and similar programs.
- * Health education material. Information pamphlets, leaflets, and other public relations material for your waiting room and other uses will be made available upon your request.
- * Advice on drugs and supplies.
- * Drug abuse. Information for physicians on drug abuse.
- * Fakes and quacks. Material on many patent medicines, fakes, quacks, and imposters can be obtained from the Indianapolis office.
- * Insurance. The Indianapolis staff can obtain from the State Insurance Commissioner accurate information regarding insurance companies of all classifications. We will be glad to check for you.

* * *

Don't forget the Indiana State Medical Association's convention in French Lick, Ind., on Oct. 20, 21, and 22, 1975! We have a dynamic program planned for your education and enjoyment. We are going to have outstanding personalities such as: Dave Hoy (T.V., radio, etc.), Coach Bobby Knight. On Tuesday evening at the President's dinner our guest speaker will be David Frost (T.V. personality from London). Suggest that you make your reservations NOW!!



Gilbert M. Wilhelmus, M. D.
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Dear Doctors:

Much has transpired this past month. First, congratulations to Dr. Lowell Steen, recently elected to the Board of Trustees of the AMA, and Dr. Pat Corcoran, elected to the Council on Medical Education.



Highlights of the annual convention of the Woman's Auxiliary to the American Medical Association, June 15-18, 1975, in Atlantic City, New Jersey, included varied opportunities for the Indiana delegation. In addition to business sessions, we heard outstanding speakers and learned from educational sessions. For the first time, this year the auxiliary offered both business and educational sessions. Because of the widespread interests of doctor's wives, the auxiliary cooperated in a joint venture with the AMA Council on Scientific Assembly to bring three sessions of general interest. 1) Estate planning for physicians and families was prepared by The American Law Institute, Philadelphia. It was conducted by H. Peter Somers of Morgan, Louis and Brockius.

2) Science and Ideals in a Hungry World was the topic of Dr. Rene Dubos, professor emeritus of Rockefeller University. 3) Sexual Enrichment was the subject of a session conducted by Harold Lief, M.D., of the University of Pennsylvania School of Medicine.

Mary Louise Smith, Republican National Committee chairman, and a doctor's wife and auxiliary member, discussed the "Health of Government." She was presented "The Woman of the Year" award.

George Plimpton, author and T.V. personality, was an entertaining luncheon speaker.

A communications clinic was directed by Robert A. Lang, executive director, Academy of Medicine of Cleveland (Ohio).

Mrs. Erle E. Wilkinson, national president, stressed Communication in her inaugural address. She emphasized communication as a positive attitude of getting through. She feels we're on the right track with our sharing of ideas and a communications system going with our "Project Bank." This concept is utilizing our greatest asset—the imagination and our idea potential of our 90,000 members.

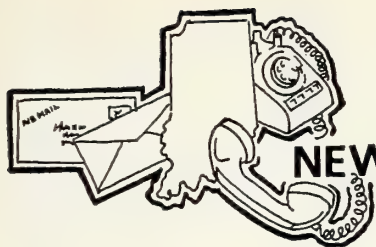
Our keynote speaker, Dr. Malcolm Todd, immediate past-president of AMA, congratulated the auxiliary for its contribution exceeding one and a third million dollars for AMA-ERF. (Indiana received a State Merit Award based on per capita giving). Dr. Todd stressed communication focusing on professional liability legislation, education and utilization review. He emphasized the need of doctors to be united now more than ever.

The challenge of Mary Louise Smith was "meet your full responsibility—it's time to put politics in your budget—your budget of time, budget of energy and budget of money." May we, too, be challenged for Auxiliary so that we may be interested, informed and involved members, and meet our full responsibility side by side with our husbands.

Sincerely,

A handwritten signature in cursive script that reads "Allie C. Reed".

Allie C. Reed (Mrs. Edsel S.)
President, ISMA Auxiliary



NEWS NOTES

Continuing Medical Education

The following organizations have received ISMA accreditation for Continuing Medical Education:

St. Catherine Hospital, East Chicago
Indiana Society of Internal Medicine
Indiana Philippine Medical Society
St. Joseph Memorial Hospital, Kokomo
Caylor-Nickel Clinic Hospital, Bluffton
Gary Methodist Hospital

Continuing Medical Education activities sponsored by these organizations receive Category I credit for the AMA Physician's Recognition Award.

Hoosier Physicians Honored For Deeds, Careers, Service

News of the honoring of a number of Indiana physicians in a variety of ways and for many different reasons has been featured in the newspapers of Indiana recently.

Dr. J. R. Hamilton, Mitchell, a long-time board member, has been named an honorary member of the Lawrence County Advisory Board of the Salvation Army.

Dr. Andrew Y. S. Chau, Terre Haute, has received notification of his appointment as state chairman of the Commission on Cancer for the American College of Surgeons.

Dr. Roland B. Wilson, Fort Wayne, was honored recently at a luncheon for 100 persons and by a Mayor's Proclamation citing him for "distinguished and dedicated service . . . to all mankind." He began his practice in Fort Wayne in 1945.

Community Hospital of Indianapolis, Inc., presented its first annual George Kuhn Physician of the Year Award to **Dr. Berj Antresian, Indianapolis**, citing him as the physician who has contributed the most to undergraduate medical education at the hospital during the past year.

Dr. Eugene Newby, Sheridan, received the "Outstanding Alumnus Award" at Commencement exercises recently for the senior class of Marion-Adams High School, Sheridan.

Dr. Robert J. Fenneman, Evansville, was recently elected president of the city's Downtown Kiwanis Club.

Dr. Steven C. Beering, dean of the Indiana University School of Medicine, and **Dr. Mark Dyken**, chairman of the Department of Neurology, were inducted as full members of the medical center's chapter of Sigma Xi recently.

The coveted Auerbach Award, given annually by the American Lung Association of Indiana, was presented to **Dr. Harold Caylor, Bluffton**, at the group's annual meeting. A former president of the association, Dr. Caylor has not missed an annual Lung Association meeting for 34 consecutive years.

Dr. John W. Deever, Indianapolis, received an honorary doctor of humane letters degree from Indiana Central University recently.

Dr. Otto F. Lehmberg, Columbia City, was honored for more than 50 years of dedicated medical service at a dinner sponsored by the Zion Lutheran congregation recently.

For his 29 years of service to the Elkhart Schools, **Dr. Vernon K. Pancost** was recently recognized with the presentation of a certificate noting his having been a charter member of the first Superintendent's Health Advisory Council, formed

in 1946, and the fact that he has continued to serve on every subsequent Council.

Dr. Wayne Crockett, Terre Haute, has been named chairman of the executive committee of the National Association of the Congregational Christian Church.

Dr. Lester H. Hoyt, Indianapolis, was elected 1975 "Employee of the Year" by the employees of Methodist Hospital, Indianapolis. Dr. Hoyt has been director of clinical laboratories at Methodist since 1956.

Whitman College in Washington has conferred an honorary degree on **Dr. John E. Jessep, Indianapolis**, chairman of the surgery department of the I.U. School of Medicine.

Dr. E. E. Richards, Russellville, was honored recently on the occasion of his retirement and tribute was paid to him for his 40-year career in the practice of medicine in Parke, Putnam and Montgomery counties.

Dr. Robert B. Chevalier, Indianapolis, was cited as one of DePauw's distinguished alumni at the University's 1975 commencement program.

Dr. C. William Goebel, Fort Wayne, was honored as a 25-year staff physician at the fourth annual Doctor's Recognition Dinner of St. Joseph's Hospital recently.

Board Certifications Announced

Drs. A. N. Larson, Fort Wayne, and Neale A. Moosey, Indianapolis, have been certified by the American Board of Surgeons.

Drs. Gary E. Underhill, Evansville, and P. J. Shah, Fort Wayne, have been certified by the American Board of Pediatrics.

Dr. Emel L. Weber, Evansville, was recently certified by the American Board of Neurological Surgery, and **Dr. Fawzy E. Salama** has been certified by the American Board of Urology.

Library Catalog Available from Ayerst

The Ayerst Audiovisual Library catalog will be supplied on request by medical society program chairmen, directors of hospital medical education and similar personnel. In addition to receiving the basic loose-leaf catalog, such requests will be honored in the future for supply of new inserts as new films and teaching materials become available. Write to Robert T. Clough, Jr., Director of Audiovisual Services, Ayerst Laboratories, 685 Third Ave., New York City 10017.

Upjohn Presents New Film

A new film "Pulmonary Complications in Shock" is offered by The Upjohn Company. It is in full color, with sound. The film is 16 mm and runs for 17 minutes. It illustrates the mechanism by which pulmonary edema may develop with volume replacement and vasopressor treatment of shock. It is available on a free-loan basis for medical meetings. Write Upjohn Professional Film Library, 7000 Portage Road, Kalamazoo, Mich. 49001.

Dr. Belshaw Wins Clevenger Award

One of this year's Zora G. Clevenger Awards for outstanding contributions to Indiana University's athletic program was presented to **Dr. George H. Belshaw, Indianapolis**.

Dr. Tether Authors Chapter

Dr. Joseph E. Tether, Indianapolis, is the author of the chapter "Myasthenia Gravis," in *Current Therapy, 1975*, published by W. B. Saunders Company, Philadelphia.

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NEWS NOTES

Continued

Family Physicians Elect Officers

Dr. Fred M. Blix, Indianapolis, is serving as president of the Indiana Academy of Family Physicians for 1975-76; **Dr. Kenneth E. Bobb**, Seymour, president-elect, **Dr. Malcolm Scamhorn**, Pittsboro, vice-president, and **Dr. George B. Keenan**, Indianapolis, treasurer.

Drs. James M. Kirtley, Crawfordsville, and **Ron Blankenbaker**, Indianapolis, are serving as speaker and vice-speaker of the House of Delegates.

AAFP delegates are **Drs. Wilson L. Dalton**, Shelbyville, and **William D. Ritchie**, Evansville, with **Drs. Alvin J. Haley**, Fort Wayne, and **Ross L. Egger**, Daleville serving as alternate delegates.

Directors whose term expires in 1976 are: **Drs. Paul Siebenmorgen**, Terre Haute; **George M. Ellis Jr.**, Connersville; **Warren L. Bergwall**, Muncie, and **Paul A. Williams**, Rensselaer.

Drs. Marshall Seat, Washington; **Kenneth Schneider**, Columbus; **L. Louis Frank**, South Bend, and **William G. Grosso**, East Chicago, are directors whose term expires in 1977.

Those whose term expires in 1978 are **Drs. Charles W. Hachmeister**, Evansville; **Jerry Stucky**, Fort Wayne; **Daniel H. Cannon**, New Albany; **Richard W. Wagner**, Huntington; **Gerald M. DeWester**, Indianapolis; **Charles Hansell**, Fort Wayne, and **Dean Felker**, Indianapolis.

Lilly Co-sponsoring Sandburg's Lincoln

Eli Lilly and Company is the co-sponsor of the NBC-TV telecast on Wed., Sept. 3, at 9 p.m. (ET), featuring "Sandburg's Lincoln: The Unwilling Warrior," starring Hal Holbrook as President Lincoln.

12 Researchers Awarded Grants For Study at Riley Hospital

Research awards totaling more than \$200,000 have been made to 12 scientists and physicians for a year of study at James Whitcomb Riley Hospital for children, Indianapolis.

The grants will be used to study hypertension, dwarfism, maternal malnutrition, small bowel transplantation and susceptibility of infection in child cancer patients. Two of the awards are fellowships to **Dr. Robert Baehner** and **Dr. Joseph F. Fitzgerald**.

Grants were awarded to **Drs. Morris Green**, Catherine G. Palmer, Robert M. Weetman, David W. Allman, Sudhir K. Anand, Laurence A. Boxer, Robert C. Karn, **Jay Grosfeld**, **Richard E. Lindseth** and James D. Northway.

Booklet on Living with Heart Ailment Offered by Public Affairs Committee

Public Affairs Pamphlet No. 521 is entitled "Living with a Heart Ailment." It is written by Theodore Irwin to explain to patients the kinds of heart ailments, the danger signals, typical treatment and rehabilitation programs, and offers precautions against recurrence. The price is 35 cents. Address: 281 Park Avenue South, New York City 10016.

Wyeth Offers Breast Self-Exam Film

A new film on "Breast Self-Examination" is available, courtesy of Wyeth Laboratories. It is a 10-minute, color-sound film aimed at encouraging women to practice breast self-examination. Write to Maternity Infant Care—Family Planning Projects, 377 Broadway, New York City 10013.

SKF Representatives Attend Course

Smith Kline & French Laboratories is sponsoring a 140-hour training course in basic biological sciences at the Medical College of Pennsylvania for SKF representatives. Instructional subjects will include pharmacology, toxicology, microbiology, chemotherapy, as well as a study of the autonomic nervous system, central nervous system, cardiovascular and renal systems, respiratory and gastrointestinal tracts.

Dr. Ian Templeton Appointed

Dr. Ian S. Templeton, Seymour, has been appointed to the Muscatatuck State Hospital Advisory Committee by Indiana Attorney General Theodore L. Sendak. Dr. Templeton's term is slated to end in 1979.

HCA Acquires St. Anthony Hospital

St. Anthony Hospital, Terre Haute, which was founded in 1882 by the Poor Sisters of St. Francis and had been operated by the Order at the same address since 1884, was acquired as of July 1 by the Hospital Corporation of America and the facility's name changed to Terre Haute Regional Hospital.

Dr. Louis G. Neudorff is chairman of the board for the new hospital. Others serving on the board are **Drs. Paul Siebenmorgen, Robert J. Burkle and Wilbert McIntosh**. Dr. Siebenmorgen is president of the hospital's medical staff.

AMA Offers Source Book on Malpractice

The AMA will publish a source document on malpractice problems in August. It will be in book form and will include all the facts and figures in one package. Words are used at a minimum; all the data that are susceptible to presentation in charts, tables and graphs will be in these forms. Order by writing to Order Department, OP-440, AMA, 535 N. Dearborn, Chicago 60610. One to 10 copies, \$1.00 each, eleven to 49, 75 cents each. Orders of 50 or more, 50 cents each. It is being written by the editors of *Prism*. If you receive *Prism*, you will get a copy automatically. If you don't get *Prism*, or if you need more than one copy, send in your order.

Ayerst Announces Medical Training Film

Ayerst Laboratories announces a medical training film on Management of Alcohol Dependency in the Medical Patient. It is 16 mm, color, sound, with running time of 30 minutes. Available on a free loan basis for medical meetings by contacting the Ayerst representative.

New Coroner for Noble County

Dr. John E. Ramsey, Kendallville, has been named Noble County coroner to complete the unexpired term of **Dr. Max Sneary, Avilla**, who resigned as of June 1.

Film on Hyperlipidemia Offered

Ayerst Laboratories announces a medical training film on Hyperlipidemia. It is 16 mm, color, sound, with running time of 24 minutes. Available on a free loan basis for medical meetings by contacting the Ayerst representative.

Wins AMA Award of Merit

Jon M. Huppenthal, a 17-year-old student at Marquette High School in Michigan City, Indiana, has received the AMA Award of Merit for his exhibit at the 26th International Science and Engineering Fair in May.

New Warrick County Hospital Elects

Dr. Albert S. Ritz, Evansville, was elected chief of staff of the new Warrick Hospital, Inc., at a recent meeting of the 18 physicians who will staff the hospital. **Dr. Robert C. Colvin of Newburgh** was elected secretary.

"Detecting Fires" Booklet Available

The National Fire Protection Association sells a book "Detecting Fires" which emphasizes the life-saving value of fire detection systems. Information applies to occupancies ranging from dwellings to health care facilities and large buildings. \$5.50 per copy.

Named ACNM Charter Member

Dr. Carl J. Elward, Wabash, is a charter member of the newly organized American College of Nuclear Medicine.

Operating Room Technicians to Meet

"Potpourri" is the title of the workshop to be given Oct. 25 at the Executive Inn, Evansville, by the Association of Operating Room Technicians of Evansville.

Tax Shelter Plan Available from AMA

The American Hospital Association has the AHA Master Compensation Deferral Plan, under which physicians who work part-time or full-time for hospitals may sequester up to 100% of their compensation in an investment entity as a tax shelter. The funds so invested may be immune to divorce or malpractice litigation. Professional corporations and partnerships may participate. The AHA has also agreed to allow employees of key medical associations to participate.



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Named Department Chairman



Dr. Hugh Curtis Hendrie, associate professor of psychiatry at Wayne State University, Detroit, and both clinical director and acting director of the Lafayette Clinic there, has been named professor and chairman of the Department of Psychiatry at the Indiana University School of Medicine and executive director of the Institute of Psychiatric Research at the I.U. Medical Center here.

He succeeds Dr. John I. Nurnberger, who retired as chairman of the department and director of the institute a year ago after 18 years in the posts. Dr. Nurnberger continues on the faculty as distinguished professor of psychiatry. For the past year **Dr. James E. Simmons**, professor of psychiatry and coordinator of child psychiatric services, has been serving as acting chairman.

Medical Assistants Elect Officers

Officers have been elected by the Indiana Society, American Association of Medical Assistants, Inc., as follows:

Miss Dorothy Muensterman, Evansville, president; Mrs. Mary Haugen, Fort Wayne, president-elect; Mrs. Penny Scubelek, Crown Point, vice-president; Mrs. Geneva Bickel, Evansville, corresponding secretary; Mrs. Mary Liz Schwab, Converse,

HELP FOR THE CONGENITALLY HANDICAPPED

CHILD It wasn't so long ago that congenitally handicapped children were allowed to reach school age or even later before being fitted with a prosthesis. In recent years, experience has shown that fitting at an earlier age produces more effective results—both mentally as well as physically. HANGER provides individually designed prostheses to give aid to the congenitally handicapped child. Children with "HANGER PROSTHESES" can live normal lives. Using their HANGER appliances they exercise freely, ride bicycles, roller skate, play basketball, tennis, and engage in most of the activities like other growing children. These activities enable the child to become self-reliant. Each HANGER prosthesis follows much the same design as those for the adult, but utilizes specially developed components of appropriate size, thus providing a smoother transition as the child grows into adulthood. HANGER also provides devices and techniques for the initial fitting of infants and problem cases. Training of children in the use of their prosthesis is highly desirable, even though children present some problems not seen in adults. Since the attention span of young children is short, extreme patience is required. Some handicaps make an ideal gait-pattern difficult if not virtually impossible to achieve. It should be noted that complete cooperation of the parent is necessary regardless of the experience and ability of the therapist. (Often the parents pass on a sense of guilt that is completely unfounded as there are no known preventive methods to combat the problem of a congenital handicap.)

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312 E. McMillan St., Cincinnati, Ohio 45219
416 N. Main Street, Evansville, Indiana 47711
3004 S. Wayne Ave., Fort Wayne, Ind. 46807

recording secretary.

Mrs. Barbara Jean Perkins, Indianapolis, is serving as treasurer, with Mrs. Evelyn Montgomery, Shelbyville, the parliamentarian and Mrs. Mary Alice Miner, Shelbyville, historian. Mrs. Phyllis Jones, Fort Wayne, is Med "A" Scoop editor, and Mrs. Betty Henderson, Bedford, is immediate past president.

Physician advisors are Drs. Leon Levi and William T. Lefler, Indianapolis, and Dr. Robert Brown, New Albany, with Dr. Donald Kerr, Bedford, serving as ISMA liaison.

Market Commentary

New highs by the industrial average give the market a very healthy look; however, the threat of a full secondary reaction still remains, in our opinion.

CURRENT TREND ANALYSIS

Transportation Average Lagging

The continuous threat of a reaction lies in the laggardly action of the transportation average.

Under the Dow Theory, both the industrial and transportation averages must move together to give a movement any real meaning.

Recently the industrial average reached new highs, but the transportation average is lagging behind. In the past, this has proved a warning signal of major importance more than once.

As explained in our June 16 Forecasts, should both averages succeed in going to new highs, the all-clear signal would be given and the market could be expected to climb another 100 points or so on the Dow before experiencing further difficulties.

CURRENT STOCK SELECTIONS

Continue Careful Buying

Until this (joint new highs) happens, however, we believe clients should continue their selective buying, concentrating in those issues that have not had big gains already this year.

The utilities qualify for such buying, as also explained in our June 16 Forecasts. Even though many have had good advances since June 16, we believe most are still undervalued and good candidates for conservative buying.

Other stocks that we believe can be bought now include Dome Mines, Alcan Aluminium, General Electric, Texaco, Atlantic Richfield, Standard Oil of Indiana, Stanley Works, IBM, Monroe Auto Equipment, Jewel and the low priced but high quality Union Bancorp.

Asarco, Allied Chemical, Caterpillar Tractor, Firestone, Hecla Mining and Beneficial Corp. are a few more issues that carry minimum risk at this point, in our opinion.

The recent sharp upthrust of the industrial average demonstrates the potentiality of this market. If this can be matched by the transportation average in the near future, 1975 may prove to be an even better year than we had anticipated.

Conclusions

On the surface, the market appears very strong, but until the transportation average demonstrates comparable strength, clients should continue their cautious buying. If the industrial average doesn't pull the transportation average up, the transportation average will pull the industrial average down. Continue to buy and hold stocks, but be very selective in all buying.—Dow Theory Forecasts, June 30, 1975. Reprinted with permission.

New Members

The Journal welcomes the following new members of the Indiana State Medical Association:

Bartholomew-Brown County

John S. Rodway, M.D., 605 Cottage Ave., Columbus 47201 (GP)

Delaware-Blackford County

Stanley A. Hoffman, 420 W. Washington St., Muncie 47305 (GS)
Gyorgy G. Polcz, 4604 Cardinal Drive, Muncie 47304 (OS)

Dubois County

Phillip R. Dawkins, 507 W. 7th St., Jasper 47546 (IM)

Huntington County

Walter T. Kirsten, P.O. Box 163, Huntington 46750 (AN)

Jennings County

Francis W. Warner, 241 Norris Ave., North Vernon 47265 (GP)
Wm. Francis Pomputius, Jr., 520 S. 7th St., Vincennes 47591 (PTH)

Marion County

James S. Cromer, 5430 E. 21st St., Indianapolis 46218 (PD)
Miguel B. Dizon, 2001 W. 86th St., Indianapolis 46260 (NM)
Phyllis R. Irwin, 3000 Meadows Pkwy, Indianapolis 46205 (FP)
M. R. Abul Khairi, 1100 W. Michigan St., Indianapolis 46202 (ORS)
Sharon M. Means, 3000 Meadows Pkwy, Indianapolis 46205 (PD)
John S. Mitchell, 3000 Meadows Pkwy, Indianapolis 46205 (PD)
Robert A. Munsick, 1100 W. Michigan St., Indianapolis 46202 (OB-GYN)
Robert E. Rogers, 1100 W. Michigan St., Indianapolis 46202 (OB-GYN)
Richard D. Telle, State Board of Health, 1330 W. Michigan St., Indianapolis 46202 (R)

Stephen C. Spicer, P.O. Box 317, Highway 114 East, Rensselaer 47978 (FP)

Owen-Monroe County

Michael Z. Silbert, 515 Woodcrest Drive, Bloomington 47401 (GS)

Rush County

Patrick W. Connerly, 604 E. 11th St., Rushville 46173 (FP)

St. Joseph County

Dean L. Cook, 919 E. Jefferson, South Bend 46622 (R)
John J. Hahn, 316 Sherland Bldg., South Bend 46601 (AN)
Dean L. Strycker, 2495 Redfield St., Niles, Mich. 49120 (AN)

Errata

The Journal regrets any embarrassment caused by errors in the Roster of Members which appeared in the June issue, as follows:

The names of the following members were inadvertently omitted:

Lake County

John P. Vincent, 904 W. Ridge Road, Hobart 46342 (ORS)

Marion County

Charles Zervas, M.D., 926 Main St., Beech Grove 46107 (GP)
David E. Copher, 3266 N. Meridian St., Indianapolis 46208 (OBG)
Matthew Cornacchione, 741 Carrollton Court, Indianapolis 46220 (GP)
Walter E. Deacon, 5037 Guion Road, Indianapolis 46254 (PH)
Ward E. Poulos, 3500 Lafayette Road, Indianapolis 46222 (PD)
Irvin W. Wilkens, (S) 4820 E. Pleasant Run Pkwy N. Dr., Indianapolis 46201 (OO)
Howard S. Williams, Jr., 1500 N. Ritter Ave., Indianapolis 46219 (IM)

Vanderburgh County

Irineo M. Nacino, R.R. 3, Box 53, Schnapf Lane, Newburgh 47630 (AN)

The address and/or medical specialty of the following physicians was incorrectly listed; the correct listing is as follows:

Clark County

Maurice E. John, 207 Sparks Ave., Jeffersonville 47130 (OPH)

Decatur

William R. Shaffer, 214 N. Franklin St., Greensburg (AN)

St. Joseph County

Magdi Gabriel, 303 South Main St., Mishawaka 46544 (ORS)

Vigo County

R. J. Reynolds, 650 Idaho St., Terre Haute 47802 (IM)

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From THE JOURNAL 50 Years Ago

In this paper it is our endeavor to give some practical rather than theoretical results of the use of luminal in the treatment of epilepsy. Our conclusions are based upon experiences with over 400 patients present in the Indiana Village of Epileptics and under our personal supervision. Specific data for comparison is only available on 184 patients present in the village in 1919, before luminal was used and who are still there. . . . All who are able are employed in some useful work. Intercurrent affections are treated as they occur. All syphilitic patients are given antisyphilitic treatment. Nearly all patients received bromides prior to the use of luminal. In about 50% of the cases the family history was negative. In the remaining cases where the hereditary factor was known, epilepsy, insanity, alcoholism and tuberculosis occurred with about equal frequency. No cause was assigned for the first seizure in two thirds of the cases. The only causes appearing frequently were gastrointestinal disturbances and trauma. In this type of seizure grand mal predominated, there being 131 cases of grand mal, 31 petit mal, 14 combined grand and petit, 11 Jacksonian and 2 psychic. . . .

In only 3 patients was it found advisable to withdraw the luminal permanently. . . .

In conclusion, we have made careful observations of our patients, striving to increase their general health and make them as comfortable, cheerful and contented as possible, and giving luminal in increasing doses until the best effect was obtained. While we do not believe luminal to be curative, yet if pushed sufficiently it nearly always controls and in a few cases completely checks the seizures and thus adds to the general well-being of the patient.—Charles F. Sexauer, M.D., Donald E. Bell, M.D., Newcastle, "Luminal in Epilepsy, Some Observations in Its Use," *JISMA* Aug. 1925.

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—June 1975

Disease	Jun. 1975	May 1975	Apr. 1975	Jun. 1974	Jun. 1973
Animal Bites	1375	1556	767	1637	1849
Chickenpox	240	634	501	389	536
Conjunctivitis	186	272	183	251	252
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	90	104	72	86	33
Gonorrhea	1082	1863	841	1532	1291
Impetigo	98	166	104	157	125
Infectious Hepatitis	45	58	50	76	64
Infectious Mononucleosis	56	91	111	42	55
Influenza	1222	2298	3317	2214	1433
Measles					
Rubeola	13	80	88	31	60
Rubella	349	268	90	65	69
Meningococcic Meningitis	0	2	1	0	2
Meningitis, Other	5	6	8	3	2
Mumps	72	462	394	142	82
Pertussis (whooping cough)	12	6	4	6	2
Pneumonia	302	424	528	509	467
Poliomyelitis	0	0	0	0	0
Streptococcal Infection	888	1400	1509	1583	1276
Syphilis					
Primary & Secondary	11	12	7	9	28
All Other Syphilis	119	115	80	144	127
Tinea Capitis	8	21	28	12	8
Tuberculosis (Active)	54	54	42	91	80

FUTURE MEETINGS, SEMINARS, COURSES

Biofeedback to Be Symposium Subject

The Continuing Education Department of Indiana University—Purdue University, Fort Wayne, will sponsor a conference on Biofeedback Sept. 4-5, at the Fort Wayne campus.

The conference, a symposium on voluntary control of psychosomatic processes, will be led by Dr. Thomas Budzynski and Dr. Johann Stoyva, staff members of the University of Colorado Medical School and pioneers in the field of Biofeedback.

The evening of Sept. 4 will feature a lecture session followed by a workshop and demonstrations of Biofeedback equipment on Sept. 5.

Fee: \$80.00. For registration or additional information, write or phone Indiana University-Purdue University, Department of Continuing Education, 2101 Coliseum Blvd. East, Fort Wayne, Ind. 46805, phone (219) 482-5526.

Coronary Surgery Wisconsin Topic

Coronary Bypass Surgery will be the subject of a 3-day symposium to be held at Milwaukee on Sept. 17, 18 and 19. Registration deadline is Sept. 1. Final program will be available on request. Write the Wisconsin Heart Association, 795 N. VanBuren St., Milwaukee 53202.

Dr. Pickel Memorial Lecturer

The Department of Pediatrics of Louisville School of Medicine announces that the 1975 John I. Perlstein Memorial Lecture will be given at 11 a.m., Sept. 22, by Donald Pickel, M.D., on the subject "Treatment of Acute Lymphocytic Leukemia in Children," in the Health Science Center Auditorium, Abraham Flexner Way, Louisville. Members of the ISMA are invited.

Child Neglect and Abuse Workshop

The Sixth National Symposium and Workshop on "Protecting the Abused, The Neglected, and the Sexually Exploited Child" will be conducted on October 28 and 29 at the Sheraton-Harbor Island Hotel in San Diego. Attendance by advance registration only. The fee is \$40, which includes two lunches. Write The American Humane Association, Children's Division, P.O. Box 2788, Denver 80201.

Breast Cancer Symposium Scheduled

The Wisconsin Breast Cancer Detection Foundation is sponsoring its First Annual Mid-American Breast Cancer Symposium, to be held on November 7 and 8, at the Concourse Hotel, Madison, Wis. The subject matter will include thermography, mammography, xerography and surgery.

Emergency Surgery Program at Cleveland

A continuing education course on "The Critically Injured Patient: Emergency Surgical and Medical Care" will be held on Nov. 13, 14 and 15 in the Marriott Inn, Cleveland, Ohio. The course is sponsored by the American College of Surgeons Committee on Trauma and Case Western Reserve Medical School. Fee for registration is \$150, except for interns and residents who pay \$50. Write ACS Trauma Division, 55 E. Erie St., Chicago 60611.

Newborn Central Nervous System Louisville Symposium Subject

The Department of Pediatrics, University of Louisville School of Medicine, presents its Ninth Annual Newborn Symposium, Nov. 13-14, 1975, to be held at the Health Sciences Center Auditorium, Abraham Flexner Way, Louisville, Ky. Dr. David Clark will deliver the 1975 Eleventh Annual Louisville Pediatric Lecture on November 12. For information write: Dr. Billy F. Andrews, 200 E. Chestnut, Department of Pediatrics, Louisville, Ky. 40202.

National Conference at Chicago on Physicians, Schools, Communities

The 15th National Conference on Physicians, Schools and Communities, sponsored by the Department of Health Education, American Medical Association, will meet on Nov. 20 and 21 at the Drake Hotel, Chicago.

Cleveland Clinic Announces Courses

The Cleveland Clinic Educational Foundation has announced its 1975-76 postgraduate course schedule. These programs in continuing medical education are accredited by the AMA and are acceptable for Category 1 credit toward the AMA Physician's Recognition Award.

Write Director of Education, The Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland, OH 44106.

1975

Sept. 8—Pharmaceuticals, Pharmacists, Physicians and the Law

Sept. 9-10—The Malpractice Crisis in Surgery and Anesthesia

Oct. 10—Medical Technology

Oct. 23—Dermatology for the Dermatopathologist and Pathologist

Oct. 29-30—Reconstructive Surgery of the Knee

Nov. 12-13—Clinical Problems in Gastroenterology

Dec. 3-4—Perspectives in Ophthalmology

1976

Jan. 7-8—Current Blood Bank Problems

Jan. 14-15—Surgical Technics, "How I Do It"

Jan. 28-29—Medical Progress for the Family Physician

Feb. 4-5—Symposium on Computed Tomography of the Head and Body

Feb. 7-8—The Environment, the Operation, the Anesthetic

Feb. 11-12—The Use and Misuse of Studies in the Diagnosis of Endocrine Disorders and The Diagnosis and Management of Diabetes and Hypoglycemia

Feb. 18-19—Practical Therapeutics in Hypertension and Renal Disease

Feb. 25-26—Sports Medicine

Mar. 3-4—Advances in Urology

Mar. 10-11—Medical Progress and Its Relationship to Dentistry

Mar. 19-20—Colonoscopy Technics and Application

Mar. 24-25—Workshops and Special Topics in Rheumatic Disease

Mar. 31-Apr. 1—Refresher Seminar in Pediatrics for Pediatricians and General Practitioners

May 1—Some Ethical Problems in Medicine

May 5-6—New Advances in Dermatology

County, District News

First District

Dr. Gilbert M. Wilhelmus, ISMA president, addressed members of the First District Medical Society at their annual meeting held May 8 at the Rolling Hills Country Club, Evansville. He thanked the physicians and members of the auxiliary for their support of ISMA's efforts to see that the professional liability insurance bill passed. In addition, he talked about the Medical Practice Act.

Dr. Bernard B. Rosenblatt, First District trustee, gave a report on what the ISMA Board of Trustees accomplished during the past year.

Dr. Ralph Carlson, Blue Shield board member, reported on Blue Shield activities.

Dr. Martin J. Bender, Evansville, was elected president; Dr. John H. Barrow, Dale, vice-president, and Dr. Herman F. Rusche, Evansville, secretary-treasurer.

Second District

Dr. Hamilton B. Lindsay of Washington was elected president of the Second District at its annual meeting held June 11 at the Vincennes Elks Country Club.

Dr. J. S. Brown, Carlisle, was reelected secretary-treasurer, and Dr. Paul W. Holtzman, Bloomington, reelected trustee.

Dr. Walter J. Daly, chairman, Department of Medicine, Indiana University School of Medicine, was the featured speaker following the business meeting.

The 1976 meeting is scheduled to be held in Washington.

Fourth District

Dr. Paul L. McHenry, associate professor of medicine at Indiana University School of Medicine, and Dr. Harold B. Spitz, professor of radiology at the University of Cincinnati, were the guest speakers at the Fourth District Medical Society meeting held June 4 at the Hillcrest Country Club, Batesville.

Dr. McHenry spoke on the Diagnosis and Management of Coronary Artery Disease and Dr. Spitz gave a report on Ultrasound.

During the day the wives of the physicians had guided tours of local industries.

Dr. Robert P. Acher, Greensburg, is the new president; Dr. Ivan Lindgren, Aurora, vice-president, with Dr. Lanny Copeland, Greensburg, serving another term as secretary-treasurer.

Dr. Alvin L. Henry, Columbus, was reelected Blue Shield director.

Fifth District

Dr. Robert C. Oehler and Dr. Nancy

L. Oehler of Brazil were elected president and secretary-treasurer, respectively, at the Fifth District Medical Society meeting held May 14 in Terre Haute. Dr. Cleon M. Schauwecker of Greencastle was reelected trustee and Dr. Edward M. Johnson, Terre Haute, was elected to serve the unexpired term of Dr. Fred W. Dierdorf of Terre Haute as a member of the Blue Shield Board. Dr. Dierdorf, whose term expires in March 1977, is moving to Florida. The 1976 meeting will be held in Clay County.

The program was furnished by Tim Spencer from the ISMA Speaker's Bureau.

Sixth District

Newly elected officers of the Sixth District are: Dr. William F. Kerrigan of Connersville, president, and Dr. Clarence G. Clarkson of Richmond, vice-president. The secretary will be elected by the Henry County Medical Society. Dr. Glen Ward Lee of Richmond was reelected alternate trustee.

Speakers at the annual meeting included Dr. Gilbert Wilhelmus, ISMA president, Dr. William E. Murray, mental health commissioner for Indiana, and Dr. Lee.

Eighth District

Approximately 20 physicians attended the annual meeting of the Eighth District Medical Society at the Portland Country Club on June 4. Discussion centered on health service agencies, the new Medical Practice Act and the Professional Liability Act. Dr. Taylor gave Blue Shield comments, and a resolution was passed in appreciation of the many years of service that Dr. Richard Ingram has given to the Eighth District.

Officers elected were: Dr. Jack Walker, Muncie, trustee; Dr. Joseph Gahimer, Anderson, president; Dr. James Moneyhun, Anderson, secretary-treasurer.

Ninth District

The Ninth District Medical Society meeting was held at the Curtis Creek Country Club in Rensselaer on June 12 with 27 doctors present for the business meeting at which Dr. Arthur Schoonfeld presided.

Dr. Vincent J. Santare, president-elect of ISMA, gave a talk about the medical liability legislation passed, and Dr. William M. Sholty, district trustee, talked about the Medical Practice Act and the medical historical building at Central State Hospital.

A resolution to increase ISMA dues by \$25 to finance Tel-Med was unanimously passed.

Representatives of about one-third of the ISMA Commissions were present and gave a report of their activities which was well received. In addition, Dr. Peter R. Petrich, Blue Shield board member, and two Blue Shield representatives, also gave reports.

Governor Otis Bowen was the main speaker at the evening meeting which was attended by 89 physicians and wives.

Allen

Dr. Robert B. Buckingham, assistant professor of medicine, University of Pittsburgh School of Medicine, was the speaker for the scientific portion of the April meeting of the Fort Wayne Medical Society. His topic was "Office Management of the Arthritic Patient." Sixty-one members attended.

Benton

Dr. Manley K. Scheurich, Oxford, has been elected secretary of the Benton County Medical Society.

Boone

The Boone County Medical Society met in Lebanon in conjunction with the Witham Memorial Hospital Medical staff on May 6 and discussed Utilization Review and Continuing Education.

Clark

New officers of the Clark County Medical Society were elected at the April 15 meeting held at the Tri County Shrine Club which was attended by 20 physicians.

The new officers are: Dr. Thomas A. Neathamer, president; Dr. Roy Fultz, vice-president and Dr. Joselito Millan, secretary-treasurer. Dr. William Greene was elected delegate to the ISMA convention with Dr. Hassi Shina chosen as alternate.

Prior to the election of officers, Lew Nimniche, a representative of U. S. Vitamin Corporation, presented a film on Hypertension which was good for four hours of credit on continuing medical education.

In addition, there was a discussion of the professional liability law, and Dr. W. T. Paynter, the Indiana State Health Commissioner, gave an extensive account of the impact on medicine in Indiana of the new Health Planning Resources and Development Act. Dr. Robert Yoho, newly appointed deputy commissioner, was also a guest and contributed to the

discussion regarding the HPRD Act, which went into effect Jan. 1, 1975.

Twenty-eight attended the May meeting.

Dr. Robert K. McKechnie was unanimously chosen to represent the society under the new Health Service Areas law.

They also passed a resolution that earlobe piercing should be under the regulation of the Health Department.

Other matters discussed at the meeting included concurrent review as represented by PSRO and utilization review.

Finally, the society voted to assess each member \$25 to raise approximately \$2,000 for the Indiana Health Federation.

Dearborn-Ohio

Dr. Verne K. Harvey, Indiana State Board of Health, spoke about Maternal and Child Health at the Dearborn-Ohio County Medical Society meeting on May 1 at the Dearborn Country Club. Twelve physicians attended.

Officers were elected at the June meeting. Dr. Rustico Dizon, Lawrenceburg, is president; Dr. Guillermo Martinez, Aurora, vice-president, and Dr. Leslie M. Baker, Aurora, continues as secretary-treasurer.

Meeting date has been changed to the first Tuesday of the month.

Dubois

Dr. Greg Ellison of Huntingburg addressed the members of the Dubois County Medical Society on Pneumonia at their March 13 meeting. Robert J. Amick, field secretary, gave a report on H.B. 1460.

Elkhart

Members of the Elkhart County Medical Society met May 8 at the Elcona Country Club and listened to Dr. William Henry L. Dornette, director of education in the Division of Anesthesiology at the Cleveland Clinic, speak about Medical-Legal Aspects of Informed Consent and Medical-Legal Aspects of Medical Records.

The program was sponsored by the South Bend Medical Foundation, Inc.

Physicians of the Elkhart County Medical Association and their wives met at the Elcona Country Club on June 26 and watched the movie "Southwest United States" presented by Mr. Herbert Sailor.

Fountain-Warren

Members of the Fountain-Warren Medical Society met May 1 in the Attica Hotel and heard a report by Dr. Peter R. Petrich on his trip to Washington, D.C., which was followed by a general

discussion of politics and the reading of H.B. 1460.

Elected to serve as officers for the year 1975-76 were: Dr. At S. Salvo, president; Dr. Hugo Brenner, vice-president, and Dr. Theodore C. Person, secretary-treasurer.

Dr. Max N. Hoffman and Dr. At S. Salvo were elected delegates to the ISMA convention with Dr. Lowell R. Stephens and Dr. Carl A. Nelson chosen as alternates.

Gibson

Dr. Don E. Pruitt, Evansville, is the new president of the Gibson County Medical Society. The secretary is Dr. David H. Lindauer, Princeton.

Grant

Dr. Robert Adams spoke to about 50 members of the Grant County Medical Society at their meeting April 22 in the new Blackford-Grant County Mental Health Building. The title of his speech was "Innovations to Be Used in Mental Health."

At the May meeting the program concerned Senior Citizens and the Geriatrics-Bradner Village.

Howard

Robert Boughman, representative of the St. Paul Insurance Company, spoke about malpractice insurance at the Howard County Medical Society meeting held May 6 at the Kings Crown Inn.

Huntington

Members of the Huntington County Medical Society held meetings at the Elks Club on March 11 and May 13.

At the March 11 meeting, 13 physicians listened to attorney George P. Adinamis give a talk about Retirement Programs.

At the May meeting the following officers were elected: Dr. Arthur N. Larson, president; Dr. Walter Kirsten, vice-president, and Dr. Barbara J. Krueger, secretary-treasurer. All are of Huntington.

Dr. J. B. Bennett was named alternate delegate.

Jay

Dr. Thomas F. Coulon, Muncie, was the guest speaker at the Jay County Medical Society meeting held at the Portland Country Club on May 7. House Bill 1460 was discussed during the business meeting.

Kosciusko

Eight physicians attended the Kosciusko

County Medical Society meeting held May 13 in Warsaw and heard Dr. Richard Finn of the Department of Psychiatry, University of Iowa, give a talk on "A Guide to Drug Treatment for Psychiatric Disorders."

Madison

Dr. Lawrence Allen, chairman of the Legislative Committee of the Madison County Medical Society, reported on H.B. 1460 at the Society's meeting of April 8.

Marshall

The Marshall County Medical Society meeting of April 1 was attended by 75 persons, including teachers, counselors, ministers, nurses, physicians and county mental health and hot line staff.

Dr. Reae Willett, head of the Northern Indiana Drug Abuse Services, gave a talk about the management of drug abuse and the place drugs find in society today.

Approximately 25 persons attended the first meeting of the society sponsored Diabetic Education Program. The program consists of four meetings with a half hour of physician teaching followed by one hour of dietitian teaching. If the pilot program is successful, it will become a permanent part of the society.

Drs. Victor C. Hackney and Max S. Norris, dermatologists from Indiana University Medical School, were scheduled to speak at the May 6 meeting.

Noble

Six physicians attended the Noble County Medical Society meeting held May 13 in the McCray Hospital in Kendallville at which Howard Grindstaff, field secretary, explained H.B. 1460, the Patients' Compensation bill.

Sullivan

The Sullivan County Medical Society's May meeting was held in conjunction with the meeting of the medical staff of Mary Sherman Hospital. Fifteen members were present to hear a report on current legislative matters by Field Secretary Robert Amick and for a discussion with regard thereto.

Steuben

Howard Grindstaff, field secretary, discussed the medical liability insurance bill with 12 physicians of the Steuben County Medical Society at their May 12 meeting in Angola.

Vanderburgh

Election of officers took place at the May 29 meeting of the Vanderburgh County Medical Society, with the following result: Dr. Ray Nicholson, president; Dr. C. W. Hachmeister, president-elect; Dr. I. L. Heimburger, vice-president; Dr. J. A. Bizal, treasurer. Drs. J. A. Marvel and J. L. Hobgood were named to the Board of Trustees, with Dr. P. E. Strueh to serve on the Board of Censors

and Drs. T. M. Harmon and W. B. Hassel to serve as delegate and alternate.

McKee received the junior division award.

Vigo

The Vigo County Medical Society awarded savings bonds to two winners in the 22nd annual West Central Indiana Regional Science and Engineering Fair recently. James Levine received the award in the senior division, and Kathy

Wabash

Seventeen physicians of the Wabash County Medical Society met at the Wabash County Hospital April 14 and heard a talk by Dr. James A. Harshman about H.B. 1460 and Utilization Review regulations.

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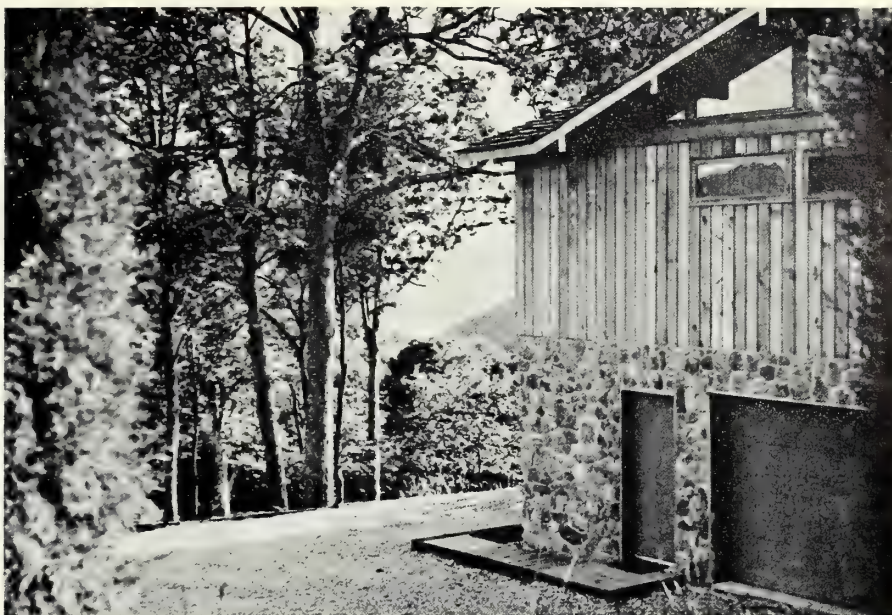
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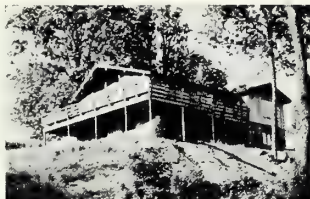
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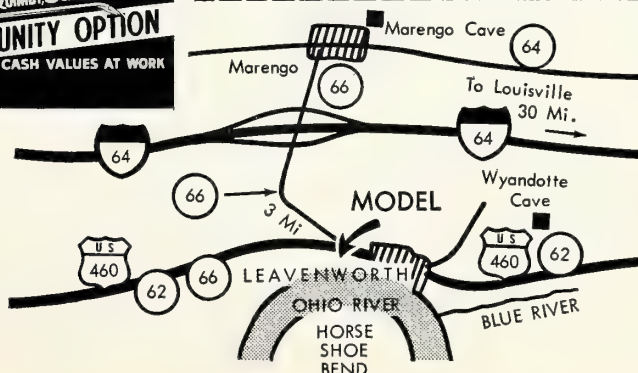


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Deaths

William E. Ballenger, M.D.

Dr. William E. Ballenger, a practicing eye, ear, nose and throat specialist in Richmond for 43 years, died April 22 in his home.

The 76-year-old physician received his doctor of medicine from Indiana University in 1928. He took graduate work at the University of Pennsylvania.

Dr. Ballenger, who practiced medicine in Winnetka, Ill., for 2½ years before coming to Richmond, was a member of the Wayne-Union Medical Society, American Medical Association, the Indiana Academy of Eye, Ear, Nose and Throat and was a senior member of the Indiana State Medical Association.

Ezra R. Haslem, M.D.

Dr. Ezra R. Haslem, 74, died April 20 in the Indiana State Soldier's Home, West Lafayette. A resident of Terre Haute, he retired in 1967 due to ill health.

He was graduated from the Cincinnati University School of Medicine and completed his internship in Ft. Wayne before he began his private practice in West Terre Haute in 1927.

Dr. Haslem, who served as a captain in the Medical Corps during World War II, was a life member of the American Medical Association, a former member of the Union Hospital staff, a member of the Vigo County Medical Society and a senior member of the Indiana State Medical Association.

Donald R. LaFollette, M.D.

Dr. Donald R. LaFollette, 48, New Albany, died May 2 at home.

A native of New Salisbury, he graduated from the Indiana University School of Medicine and opened his practice in New Albany in 1953.

He was a Navy veteran of World War II and a member of the boards of advisers for Indiana University Southeast and Silver Crest Hospital in New Albany.

Dr. LaFollette, a former vice-president of the Floyd County Medical Society and a member of the American Medical Association, served on the staff of the Floyd County Memorial Hospital.

Harold B. Lehman, M.D.

Dr. Harold B. Lehman, 53, a native of Berne, died April 25 in a hospital at Columbus, Ohio.

He practiced a number of years in Berne following graduation from Indiana University School of Medicine in 1949 and before moving to Portsmouth, Ohio.

Dr. Lehman was a former member of the Indiana State Medical Association.

H. Allison Miller, M.D.

Dr. H. Allison Miller, retired physician and surgeon of Marion, died May 5 in Marion General Hospital.

The 71-year-old physician was a graduate of the Indiana University School of Medicine.

Dr. Miller was a member of the Grant County Medical Society, the American Medical Association, American College of Surgeons, and was a senior member of the Indiana State Medical Association. He also was a former commander of the medical detachment of the 150th Field Artillery, Indiana National Guard.

Virgil C. Miller, M.D.

Dr. Virgil C. Miller, 65, died April 11 in Woodlawn Hospital, Rochester.

A graduate of the Indiana University School of Medicine in 1935, he began his practice of medicine in Akron in 1936.

Dr. Miller was a former president of the Fulton County Medical Society, and was a member of the American Medical Association and the medical staff of Woodlawn hospital.

Edward T. Stahl, M.D.

Dr. Edward T. Stahl, an orthopedic surgeon at Arnett Clinic for 45 years, died April 13 in St. Elizabeth Hospital. Dr. Stahl, who retired in 1974, was 71.

He earned his medical degree in 1928 from the Indiana University School of Medicine.

Dr. Stahl was a member of Alpha Omega Alpha, the Indiana Bone and Joint Club, and served on the Home and St. Elizabeth Hospital staffs. He also was the former chief of staff at St. Elizabeth and served as president of the Arnett Clinic in 1940, 1943 and 1947.

He was a member of the Tippecanoe County Medical Society, the American Medical Association, and was a senior member of the Indiana State Medical Association.

Dwight H. Murray, M.D.

Dwight H. Murray, M.D., 86, former president of the American Medical Association and an honorary member of the Indiana State Medical Association, died Oct. 7, 1974, in Queen of the Valley Hospital, Napa, Calif.

Born in Lawrence County, Ind., Dr. Murray received his M.D. degree from the Indiana University School of Medicine in 1917. Dr. Murray was on destroyer patrol service with the Marine Corps for the next two years and then spent three more years in the service.

Following his discharge in 1922, Dr. Murray moved to Napa, where he became a general practitioner specializing in internal medicine. He continued to practice until his death.

In 1945, Dr. Murray was elected to the AMA Board of Trustees, and became president of the association in 1956. In 1961 he was made chairman of the Board.

On Oct. 18, 1956, the House of Delegates of the Indiana State Medical Association adopted a resolution making Dr. Murray an honorary member.

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PURDUE DEFIBRILLATION CONFERENCE

The Biomedical Engineering Center of Purdue University will hold a conference in Lafayette, Indiana, from October 1 to 3, 1975, covering the practical and clinical aspects of cardiac defibrillation. The speakers have been selected based upon their positions as leaders in their respective fields. The topics to be discussed include clinical, basic science, and engineering aspects of electrical defibrillation as it pertains to the needs of physicians, nurses, emergency medical personnel, hospital engineers, equipment manufacturers, and research scientists. The state-of-the art of defibrillation techniques will be presented and examined critically and a major goal of this three-day conference will be to integrate all available technology for optimization of ventricular defibrillation. The registration fee of \$95 includes proceedings and two luncheons.

For further information, please Write: Division of Conferences and Continuation Services, Stewart Center, Purdue University, West Lafayette, Indiana 47907; or Phone: (Area Code 317) 749-2533

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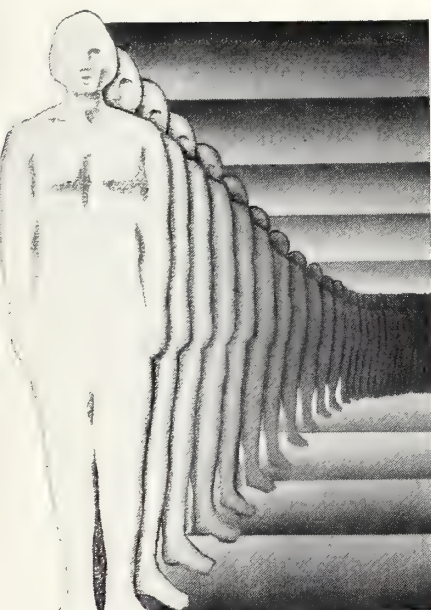
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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 to 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous



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Nutley, New Jersey 07110

LIBRIUM®

chlordiazepoxide HCl/Roche
5mg, 10mg, 25mg capsules

**IN PAINFUL
ACUTE
CYSTITIS***

*nonobstructed;
due to susceptible
organisms



RELIEVE THE PAIN WHILE YOU ELIMINATE THE PATHOGENS.

FOR THE PAIN

- ☐ **Early relief of painful symptoms** such as burning and pain associated with urgency and frequency.

FOR THE PATHOGENS

- ☐ **Effective control of susceptible pathogens** such as *E. coli*, *Klebsiella-Aerobacter*, *Staph. au-*

reus, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*.

Appropriate antibacterial therapy: Up to 3 days therapy with Azo Gantrisin 4 to 6 tablets *Stat.*, then 2 tablets *q.i.d.*; then 11 days with Gantrisin (sulfisoxazole) may be considered.

AZO GANTRISIN[®]

(50 mg phenazopyridine HCl and 0.5 Gm sulfisoxazole)

Before prescribing, please consult complete product information, a summary of which follows.

Indications: In adults, urinary tract infections complicated by pain (primarily cystitis, pyelitis and pyelonephritis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Important Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media for patients already taking sulfonamides. Increasing frequency of resistant organisms currently is a limitation of the usefulness of antibacterial agents including the sulfonamides. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 12 to 15 mg/100 ml is considered optimal for serious infections; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period. Contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with gastrointestinal disturbances, because of phenazopyridine HCl component.

Warnings: Safe use in pregnancy has not been established. Teratogenicity potential has not been thoroughly investigated. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis. *C.N.S. reactions:* Headache, periph-

eral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, polyarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Usual adult dosage for acute, painful phase of urinary tract infections is 4 to 6 tablets initially, then 2 tablets four times daily for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment of the infection with Gantrisin (sulfisoxazole) may be considered.

Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine soon after ingestion.

How Supplied: Tablets, each containing 0.5 Gm sulfisoxazole and 50 mg phenazopyridine HCl —bottles of 100 and 500.



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The JOURNAL

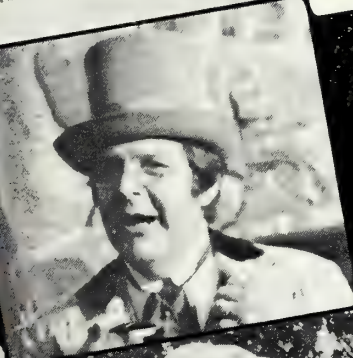
OF THE INDIANA STATE
MEDICAL ASSOCIATION

September 1975

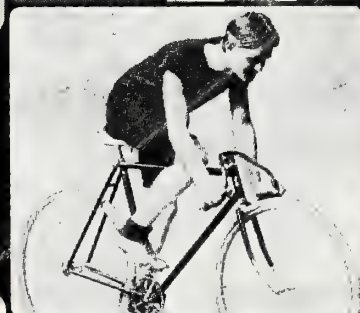
Vol. 68 • No. 9

Indianapolis

*The
Wisest Man
in the Valley*



*Because
I Was
Too Young...*



ISMA ANNUAL MEETING
October 20-22, 1975 • French Lick

Both often



- Predominant psychoneurotic anxiety

- Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor

neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent

in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium[®] (diazepam) 2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-sedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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Letters

to the editor

To the editor:

I note on page 665 of the July 1975 JOURNAL in the Editorial Notes section a comment on the reduction of highway fatalities. The question is raised whether the decrease in Indiana highway fatalities in 1975 is due to the 55 MPH speed limit or to less driving due to less gasoline.

It is interesting to me as a physician deeply involved in emergency medical services to read comments such as these and comments that the reduction of traffic fatalities is due to the fact that police departments are writing more traffic tickets, etc.

The reason I am interested is that I feel that perhaps the reduction in fatalities may also be due to the vastly improved emergency medical care rendered to highway accident victims in the state of Indiana as a result of the continually accelerating programs to train ambulance technicians and to provide them with better vehicles, equipment and communications.

Obviously, there is no way to tell which factors are involved in decreasing highway fatalities. However, it would be nice to read just once that someone is giving some credit to this large group of people—emergency ambulance technicians, emergency department physicians and nurses, etc.—whose hard work and devotion to the ideals of improved emergency care *must* be a factor in decreasing our highway death toll.

JOHN G. SUELZER, M.D.

Director, Ambulance Division
Marion County General Hospital
Indianapolis

Taking a Chance

Editor, The Wall Street Journal:

Your editorial "The Risks of Safety" (June 26) brings back memories.

In 1947 I was in our local sanatorium with service-connected TB. I had tuberculosis not only in the lungs but also in the throat, which was almost always fatal. I could hardly eat and guessed I had maybe two months to go, although I hadn't given up hope.

One day the medical director came to me and said, "Walter, there's a new drug, it may have side effects and it's so new the Vets won't pay for it. I'll let you have it for cost. Do you want to try it?" Of course I did. The drug was streptomycin; the cost was \$1 a shot for 360 shots—one every six hours.

I'll never forget the throat specialist, who came up once a month, on his next visit. He looked in my mouth and said, "It's a miracle!" My throat was clear. Six months later I'd gained 70 pounds and was discharged with no side effects and have had no problems since.

If our present regulations concerning the release of new drugs were in effect then, I would have been dead for 28 years. I doubt if the doctor had heard of malpractice in those primitive days—I certainly hadn't.

Maybe this sort of experience makes people like me conservative. "Progress" doesn't necessarily mean "better."

WALTER A. ROTHERMEL
Wyomissing, Pa.

From THE JOURNAL 50 Years Ago

I. The patient with congestive cardiac decompensation requires (a) rest, even if opiates and such special postural devices as the Gatch bed, ventral supports, etc., are necessary; (b) the physiological effect of digitalis (augmented in cases with much fluid by theocin); (c) a minimal intake (starvation or Karel diet). In the event of impending cardiovascular collapse the immediate indication is for caffeine sodium benzoate intravenously and ouabain rather than digitalis. Phlebotomy to be effective in badly congested patients must remove at least 300-400 c.c. blood. (All these procedures are considered in detail).

II. The satisfactory management of anginal cardiac decompensation demands (a) relief from the anginal paroxysm, and (b) intelligent treatment of the underlying pathological condition, usually either an aortic lesion or hypertensive myocarditis. Amyl nitrite, trinitrin, and morphine have been of most use in relieving the paroxysm; our experience with surgery in this connection has been too limited to warrant an opinion. Treatment of the usual underlying conditions is exemplified in case reports.

III. The chronic cardiac patient with "impending decompensation" (a very limited cardiac reserve) may often be reclaimed from invalidism and restored to a life of comparative usefulness if his problem is studied individualistically, from the social service as well as the medical point of view . . . —"The Treatment of Cardiac Decompensation," by James Wynn, M.D., Indianapolis, JISMA, September 1925

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unique 10-grain buffered aspirin

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All articles must be typewritten, double-spaced with margins of one inch.

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Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

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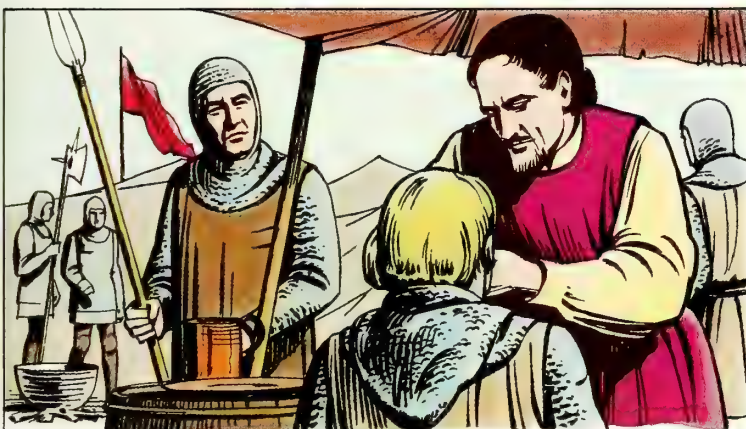
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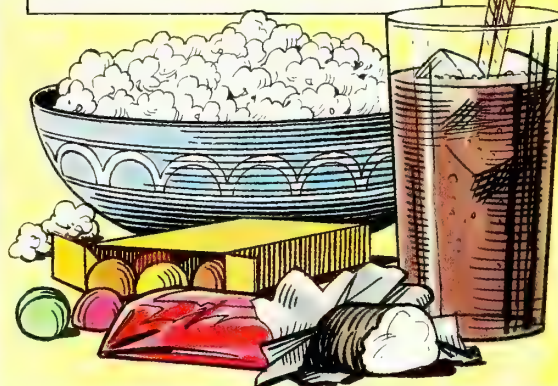


The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.



De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food." The disease he described was probably scurvy.

A 1965 U.S.D.A. survey revealed that American diets were lower in vitamin C than they had been 10 years earlier!



The outer leaves of cabbage and brussels sprouts contain more vitamin C than the heads. Yet, ironically, these are often trimmed away by the grocer to improve appearance and enhance sales appeal! Many housewives trim them even more before cooking!

Available on your
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(warning: may be habit forming)			

Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients

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This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

THE AMERICAN MEDICAL ASSOCIATION HAS FILED a lawsuit to block the implementation of new federal drug regulations that would pressure physicians to prescribe low-cost drugs for Medicare and Medicaid patients.

The Maximum Allowable Cost (MAC) regulations were approved in final form by Health, Education, and Welfare Secretary Caspar Weinberger a few days before he left office.

Within 24 hours AMA filed suit in Northern Illinois District Court contending the program is the epitome in regulatory control—"an impossible labyrinth of drug regulations without assuring a favorable cost-benefit ratio."

The AMA contends the constitutional rights of both patients and physicians would be violated and that the program would produce adversary relationships among patients, physicians and pharmacists.

The disputed regulations would require pharmacists filling prescriptions for Medicare-Medicaid patients, primarily Medicaid, to be reimbursed on the basis of the lowest cost at which the product is generally available to providers. A higher-priced drug reimbursement would be allowed only if the physician signs that it is "medically necessary." The purpose is to stimulate purchase of generic drugs and discourage purchase of brand names that carry higher costs.

By and large, physicians will be affected as they deal with Medicaid patients since there is no substantial outpatient benefit for Medicare. In states with anti-substitution laws, a Medicaid prescription for a brand name more expensive than the MAC would mean the patient would have to make up the difference in price unless the physician would be willing to change the prescription to another brand or generic prescription or sign that it is medically necessary.

At an HEW news conference, officials predicted most physicians would go along with the program, estimating that one-half of one percent would use the "medically necessary" route for brand names that exceed the MAC.

The AMA suit, however, argues that the regulations "violate every one of the drug-reimbursement requirements of the Medicare-Medicaid statutes" and defy the law, inasmuch as they represent government inter-

ference with medical practice by telling physicians which drugs they should prescribe.

Weinberger estimated the MAC program would save federal and state governments \$60 million to \$75 million a year when it swings into full operation within three to four years.

In addition to the control program, HEW will send all physicians a list of most frequently prescribed drugs along with the prices community pharmacies pay for them. The aim is to encourage physicians to prescribe cheaper products in their regular, private practice.

No sanctions are provided for physicians who decide to write out the "medically necessary" prescription message, but HEW officials speculated that state health agencies might take a look at physicians who do this consistently for all their Medicaid patients. The possible penalty by the state, if it wishes, would be ouster from Medicaid participation, according to the HEW officials.

Before a Maximum Allowable Cost can be established for drugs, the Food and Drug Administration must first indicate that there are no bioequivalence problems among its several brands. The HEW Pharmaceutical Reimbursement Board would then propose a MAC at a level equal to the lowest cost at which the drug is generally available to providers. Before the MAC can officially be established it must be reviewed by a non-governmental advisory committee and published in the *Federal Register* for comment.

The regulations establish both the Pharmaceutical Reimbursement Board and the five-member outside advisory group.

HEW said about one quarter of commonly prescribed drugs are available from multiple sources. However, the number for which bioequivalence problems can be ruled out is smaller.

The reimbursement that a pharmacist receives for drugs he provides Medicare and Medicaid patients will be based on an estimate of his cost of buying the drug plus a dispensing fee, or on his usual charge to the general public, whichever is the smaller. Program agencies such as a state Medicaid program would make the estimates according to price information supplied on a regular basis by HEW.

Continued on page 762

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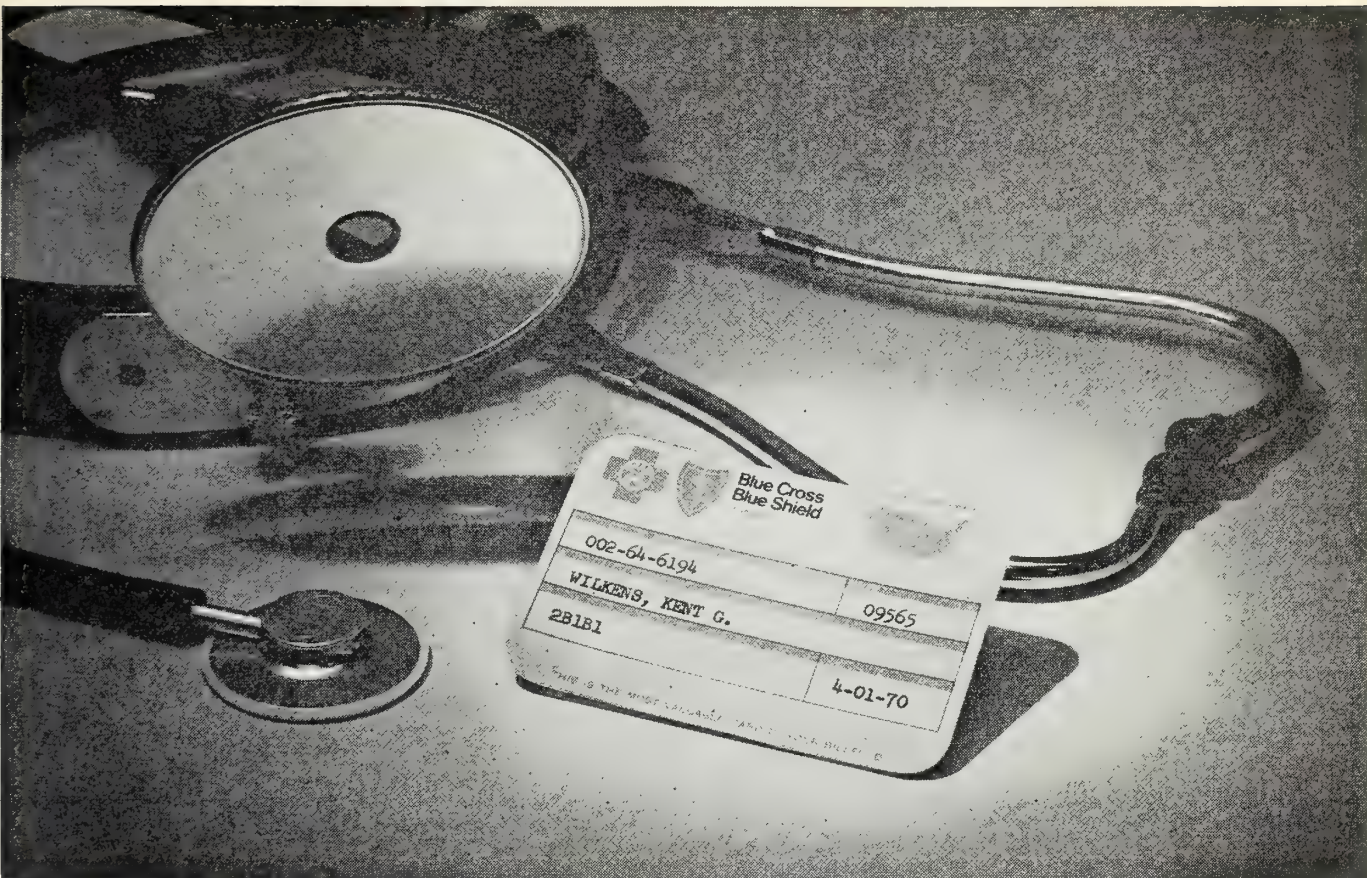
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2.	Hamlin B. Lindsay, Washington	J. S. Brown, Carlisle	Washington
3.	Claude J. Meyer, Jeffersonville	Charles X. McCalla, Paoli	Sept. 13-14, Clarksville
4.	Robert P. Acher, Greensburg	Lanny Copeland, Osgood	Greensburg
5.	Robert C. Oehler, Brazil	Nancy L. Oehler, Brazil	Brazil
6.	Wm. F. Kerrigan, Connersville	Clarence G. Clarkson, Richmond	
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9.	Arthur Schoonveld, Brook	Kenneth Ahler, Rensselaer	
10.	Joseph M. Siekierski, Griffith	James R. Brown, Valparaiso	Sept. 24, 1975, Valparaiso
11.	George W. Wagoner, Delphi	Fred Poehler, La Fontaine	Sept. 17, 1975, Delphi
12.	J. Robert Edwards, Auburn	Thomas A. Felger, Fort Wayne	Sept. 11, 1975
13.	John O. Hildebrand, Jr., South Bend	David L. Spalding, Mishawaka	Sept. 10, South Bend

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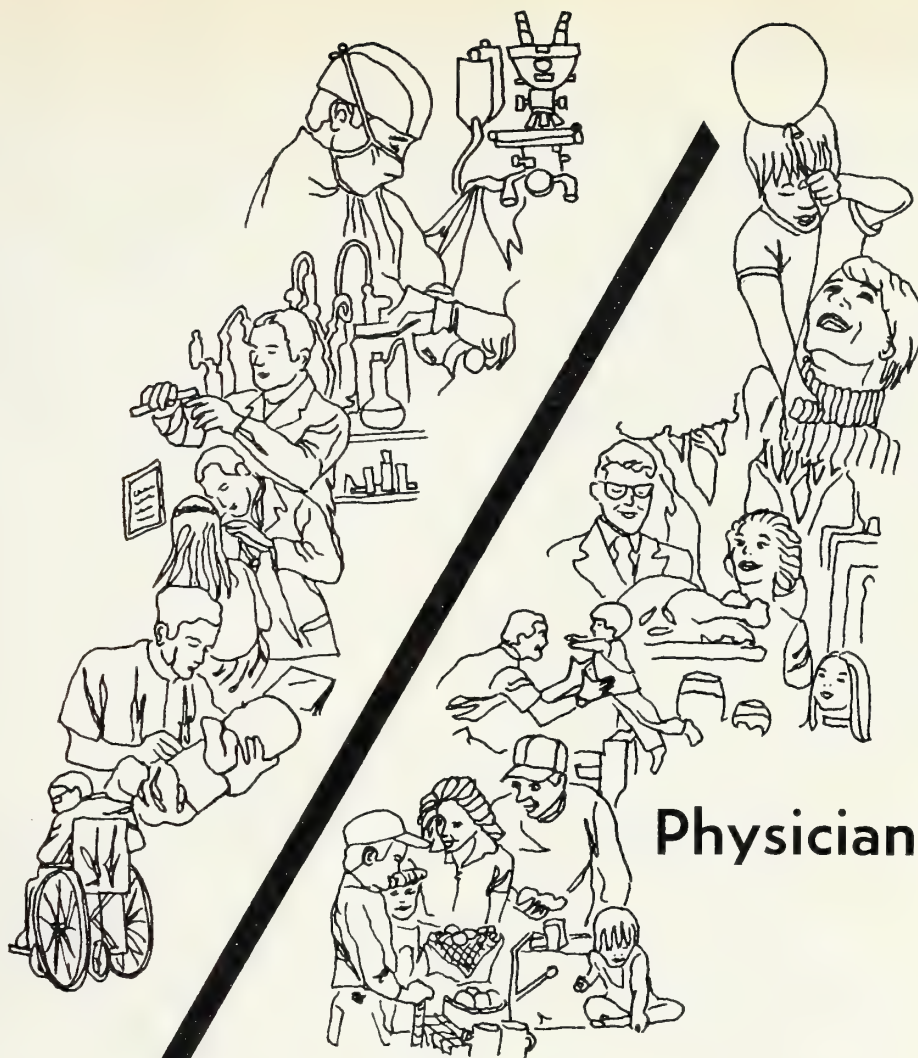
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The original MAC proposed regulations were amended in some respects. At first, it was recommended that exceptions would be made only if physicians certified the drug was the only one effective or that could be tolerated by the particular patient.

An FDA official said this section was changed in an attempt to meet AMA objections.

The MAC program isn't slated to begin for eight months and will cover at the start some 15 to 20 drug classifications.

Some 2,600 comments were filed with HEW on the MAC proposal with less than 300 favorable.

A HEALTH MANPOWER BILL COSTING \$1.7 BILLION to aid medical and other health schools has been approved by the House of Representatives.

The measure was stripped on the House floor of a provision that would have regulated residency assignments and ration them by specialty. However, a controversial "payback" provision for medical students did survive the floor fight, though it was watered down.

The AMA waged an all-out drive against both the residency control and payback provisions in the first big medical-legislative battle of the Congressional session.

Though the payback plan was retained in the bill, it was changed on the floor to include a "grandfather" clause exempting all current students, and to allow them a total of three years (instead of 11 months) to begin their payback, either in cash or in shortage area services, and allowing forgiveness for military service.

The hotly disputed payback would amount to some \$2,000 a year, that portion of the individual student's yearly medical education subsidized by the federal government. It marks the first time that general subsidies to schools would be required to be repaid by students at the schools, and is expected to raise legal questions on constitutionality if it becomes law.

As a result of the amendments on the House floor, no one would be faced with the payback requirement until 1985 or 1986, provided the plan is enacted into law and survives possible court challenge.

Some fancy parliamentary maneuvering blunted the anti-payback forces drive. Manager of the bill, House Health Subcommittee Chairman Paul Rogers (D-Fla.) steered through the palliative "payback" amendments before calling for a vote. The vote to support the provision was 209-153. Under House rules a vote could not then be taken to reject the amended provision.

Leading the battle against the payback plan was Rep. David Satterfield (D-Va.) who charged it "will certainly violate the spirit, if not the letter, of our Constitution."

Terming the plan "a finely baited snare," Satterfield said the medical graduate has to make the decision on cash repayment or service "at a time when he is faced

with repaying loans made to provide for his education, the cost of setting up an office, paying for malpractice insurance, and perhaps supporting a family.

"The saddest aspect of all is that the ones who will have no choice but to enter into a period of service will be those medical graduates who come from the poorest families or those with moderate incomes, because under the circumstances they will not be able to do otherwise."

The service payback would be on a year-for-year basis, and, for those choosing this option, four years of service would be required in most cases. Otherwise, they would have to pay Uncle Sam \$2,000 a year or \$8,000 in a lump sum.

THE HOUSE VOTED TO LIFT the \$36,000 a year salary lid for Veterans Administration physicians and dentists.

The measure, approved on a 382-3 vote and sent to the Senate, would provide \$5,000 a year in special pay and \$8,500 a year in incentive pay for physicians and dentists working full time for the V.A. between Sept. 28, 1975 and Sept. 25, 1976. Part-time physicians would be limited to \$41,000 and part-time dentists to \$36,000.

Medical professionals in the armed forces and the Public Health Service previously had been voted bonus pay.

The American Medical Association had urged Congress to approve the higher pay for V.A. physicians. Still to be resolved is the \$36,000 pay ceiling for other federal physicians under regular civil service.

THE HOUSE WAYS AND MEANS SUBCOMMITTEE on Health has opened the first Congressional sessions of the year on National Health Insurance.

Subcommittee Chairman Dan Rostenkowski (D-Ill.) said the purpose was to provide Congress with an overview of the problems involved in NHI and the thinking of experts in the field who are not formally aligned with any outside group seeking passage of specific legislation.

Rostenkowski also announced full-scale formal hearings on NHI will start in early fall, at which specific time legislation will be considered.

Four all-day sessions have been conducted to date, with a fifth session scheduled for September.

Here in capsulated form is a sampler of the views expressed before the subcommittee by some of a host of witnesses:

Dr. E. L. Wynder, president of the American Health Foundation, devoted most of his testimony to urging emphasis in any national program on preventive medicine.

Dr. John Freymann, president of the National Fund for Medical Education, called the present health care

Continued on page 765



Putting out the fires of arthritic pain

Rheumatoid arthritis can sometimes spread like wildfire, with joint after joint going up in flames. The usual onset is manifested by spotty joint involvement but an acute onset of symmetrical polyarthritis may be noted.^{1,2,3}

If aspirin fails, consider Butazolidin alka. Giving one capsule four times a day often provides prompt, pain-relieving, anti-inflammatory action to help restore joint mobility. The results you can get within a week can be maintained on as little as one or two capsules daily.

Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions. For full details, please read the prescribing information. It's summarized on the back of this page.

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Ragan, C. The Clinical Picture of Rheumatoid Arthritis. In Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia: Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty. **Indications:** Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.

Contraindications: Children 14 years or less, senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias, renal, hepatic or cardiac dysfunction; hypertension; thyroid disease, systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpre-

dictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dys-

pepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy, CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement (B)98-146-070-J (10/71)

For complete details, including dosage, please see full prescribing information

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system a "monstrosity." At the same time, he criticized national health in other countries for stifling innovation. Dr. Freymann urged caution in erecting a national health plan here. "We must build on what we have," he said.

Rashi Fein, economics professor at Harvard University, took the approach that NHI is "a hallmark of a civilized" society in which medical care costs are shared so that the poor have equal access. He opposed catastrophic, and, without directly saying so, appeared to be supporting the labor NHI bill.

Uwe Reinhardt, economics professor at Princeton University, noted that West Germany's highly nationalized health care system has a worse infant and maternal mortality rate than the U.S. He said there are many very good points about the American system and warned that there are no legislative panaceas. Not only might legislative proposals not result in improvement of health, "but they may cause developments we do not like."

Herman Somers, Princeton professor, suggested that the government become more deeply involved in financing of health care costs, not in its administration. Discontent with the U.S. health system is not due to poor conditions but to greater public expectations. Health care is better now than ever. Present problems are due as much to the government as to the private sector's own faults.

Robert England, M.D., a private practitioner of Carlinville, Ill., was one of the few non-academic physicians to appear before the subcommittee. He said the Indians of this country are the beneficiaries of complete Federal health care and have the worst health of any group in the nation. Labor's aim, Dr. England said, is to shift health costs to the general public so it can negotiate better wage and other agreements from management. Corporations think the same way, he charged.

John Thompson, president of Blue Shield of Massachusetts, thought Congress should view the NHI debate "not in the perspective of the government's desire to continually expand in numbers and services but rather as to which entity can provide services to the public on the most cost-effective basis."

Wilbur Cohen, former HEW Secretary and now the dean of the University of Michigan School of Education, said he didn't favor enacting any of the NHI bills before the subcommittee. He said developing a NHI bill should be a long and continuing process with time to consult fully providers and consumers. Only the executive branch can do this, he said, charging the present Administration is "tragically incompetent." This isn't the year for Ways and Means to act on NHI, he said. The public must be fully educated about NHI. Benefits should be phased in slowly with a definite schedule, and the program should be administered outside of HEW by a board of three to five people. The

longer Congress deliberates on NHI, the better. Swift action would be "a tragic mistake" for "so monumental an undertaking."

Martin Feldstein, economics professor at Harvard, criticized the incentive health insurance provides for hospitals to produce more and better services yet without providing consumers the protection they need against catastrophic costs.

Herbert Klarman, economics professor at New York University, said there's no health care crisis. Some problems today simply reflect past successes. The present system is largely effective. NHI should be a financing instrument only.

Avedis Donabedian, M.D., professor of medical care organization at the University of Michigan, discussed the problems of defining quality care. Too much emphasis should not be given to statistics or to technological procedures at the expense of personal relationships involving physicians and patients. The PSRO program faces two dangers—it might be implemented half-heartedly and it might use the wrong standards. If both results occur, as he predicted they would, neither much harm nor much good would result, but a large bureaucracy would be created.

Rep. Charles Vanik (D-Ohio), apparently irritated at the defense of the private sector, said most of the doctors he knows think Attila the Hun is a terrible liberal. There are severe problems in health care in this country, Vanik said, such as finding physicians, waiting in hospitals. Congress doesn't "sit here and dream up plans in the night to extend the gargantuan of the federal government. We are pushed and shoved into this by angry constituents." ◀

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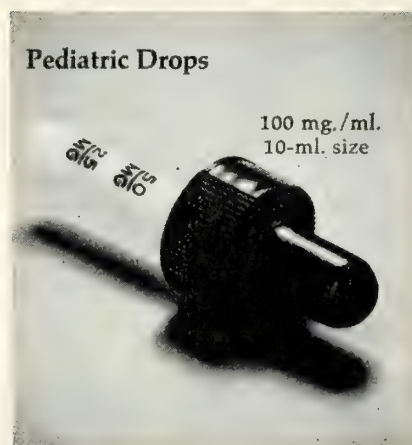
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Management of the Diethylstilbestrol Exposed Female

J. CRAIG STRAFFORD, M.D.
CLARENCE E. EHRLICH, M.D.
Indianapolis

Introduction and Discussion

IN April 1970 Herbst and Scully reported a cluster of seven cases of a rare type of vaginal adenocarcinoma in adolescent females whose mothers had been treated with diethylstilbestrol (DES) in pregnancy.¹ A registry of Clear-Cell Adenocarcinoma of the Genital Tract in Young Females was established and, from 1970 to 1974, 170 cases were reported in women 7 to 29 years of age by hospitals from every geographic region of the United States.² Although estimates of the exposed population vary greatly, a minimum of 10,000 and a maximum of 50,000 daughters were born to DES pregnancies each year between 1960 and 1970 and an unknown and possibly larger number between 1945 and 1960.³ DES and related non-steroid estrogens were used to maintain pregnancy in cases of threatened or habitual abortion and in patients with a history of previous stillborn or premature delivery.⁴ Herbst et al.² have reported the

appearance of vaginal adenocarcinoma and adenosis in offspring who were exposed to as little as 1.5 mg of DES daily throughout pregnancy, and for as short a period as seven days during the first trimester. In the epidemiology of vaginal clear-cell adenocarcinoma, the critical time for exposure appears to be the first 18 weeks of gestation.² The incidence of malignant disease within the exposed population is quite small (<1%). Whereas vaginal adenosis, found in 97% of DES exposed offspring, is considered benign⁵, clear-cell adenocarcinoma of the vagina and cervix has at least a 25% mortality.²

Abnormal vaginal bleeding or vaginal discharge are the presenting symptoms in 76% of patients with clear-cell adenocarcinoma of the vagina.² More disconcerting are the 16% of patients with vaginal or cervical adenocarcinoma who are asymptomatic and who clearly establish the necessity for examination of all known DES exposed females.² Any asymptomatic menarchal or symptomatic patient with the possibility of DES exposure in utero deserves a thorough pelvic examination.

On pelvic examination, the an-

terior upper third of the vagina, the area most frequently involved with the lesions of adenosis or adenocarcinoma, is carefully inspected visually and by palpation. Hospitalization, anesthesia and visualization of the vagina through a hysteroscope may be necessary in the very young symptomatic patient. Non-neoplastic abnormalities associated with in utero DES exposure include cervical erosion (ectropion), vaginal adenosis, cervical hooding and "cockscomb" cervix.² Cervical erosion was present in over 90% and vaginal adenosis in 97% of the cases of adenocarcinoma.² Cytologic scrapings should be obtained from the lateral and anterior vaginal walls in addition to the usual cervical sampling. Cytology was positive in 76% of Registry cases with a false negative rate of 21%.² Schiller's iodine staining and biopsy of suspicious areas is recommended. Colposcopic visualization and directed biopsy are desirable but not necessary for adequate screening of the DES exposed patient.

Patients with clear cell adenocarcinoma of the vagina or cervix are staged according to the standard FIGO classifications,² and are

From the Gynecologic Oncology Section, Department of Obstetrics and Gynecology, Indiana University Medical Center, Indianapolis 46202.

treated on an individualized basis by surgical excision, radiation or a combined approach.

DES exposed patients with vaginal adenosis or other non-neoplastic abnormalities should be followed at frequent intervals (i.e., every 3-12 months). No confirmed progression of vaginal adenosis to adenocarcinoma or any other malignancy has been shown and its significance is unknown. Adenosis of the vagina has been treated by excision, fulguration, cryoprobe and hormonal therapy. Only the latter has shown any success in decreasing the amount of adenosis.⁶ We think that no therapy for vaginal adenosis is indicated unless symptomatic. DES exposed patients who are asymptomatic and in whom no abnormality has been found may be followed at 12-month intervals beginning at menarche.

Conclusion

Management of the DES exposed female entails identification of individuals at risk, through pelvic examination of menarchal or symptomatic patients and follow-up at 6- to 12-month intervals in patients

Management of the DES Exposed Female

1. Pelvic Examination
 - A. At any age, if symptomatic
 - B. After menarche, if asymptomatic
2. Vaginal and Cervical Pap Smears
3. Schiller's iodine staining
4. Colposcopic examination
5. Biopsy—abnormal areas detected with iodine stain or colposcopy
6. Treatment
 - A. Normal examination—follow yearly
 - B. Non-neoplastic abnormality—follow every 3 to 12 months
 - C. Adenocarcinoma—individualized treatment

without evidence of malignancy. An American College of Obstetricians and Gynecologists Technical Bulletin,⁷ recommends notification of DES treated patients in instances where prenatal records are available so that their daughters can be examined. At present there is no evidence to indicate that males have been affected by intrauterine DES exposure.⁷ The diagnosis of clear-cell adenocarcinoma of the vagina or cervix requires individualized therapy with surgery, radiotherapy

or both. The possibility for development of other genital tract malignancies in the DES exposed population is unknown.

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Indiana Maternal Mortality Committee

—Past, Present and Future

WILLIAM D. RAGAN, M.D.
Indianapolis

A NY group of deaths in which fully two-thirds of the total number can be prevented, immediately becomes a pressing problem."¹

The number of maternal deaths in Indiana over the past 10 years has averaged 20 to 30 per year. In order to eliminate the preventable maternal deaths and improve maternal care in Indiana, information gathered on these deaths must be better utilized.

The first maternal mortality study originated in Philadelphia in 1931. Most states now have Maternal Mortality Committees. Under the leadership of Drs. C. O. McCormick, Sr., and Carl P. Huber of Indianapolis, the Indiana Maternal Mortality Committee was set up in March 1955. This committee is sponsored by the Indiana State Medical Association, the Indiana State Board of Health, and the Indiana University School of Medicine. The sole objective of this committee is the reduction of maternal mortality.

There has been a phenomenal achievement in this field. In 1930 the maternal mortality in the state of Indiana was 60 deaths per 10,000 live births. The maternal mortality is now 2.5 deaths per 10,000 live births. One might question the present need for such a committee, but since most of these deaths have preventable factors there is still an obvious requirement and pressing concern.

Past and Present

The Maternal Mortality Study Committee is composed of members primarily interested in obstetrics and those representing specialties perti-

nent to obstetrical problems. Those members not subject to appointment by the Indiana State Medical Association are shown in Table 1.

Those appointments made by the President of the Indiana State Medical Association are listed in Table 2.

Method of Operation

The original method of operation was outlined in an article published

by Dr. C. O. McCormick, Sr. in *The Journal of the Indiana State Medical Association* in October 1956.² There is a direct liaison with the committee and the Director of the Maternal and Child Health Division of the State Board of Health, all county medical societies, the Indiana Section of the American College of Obstetricians and Gynecologists, the Indiana Academy of Family Practice, local

TABLE 1

	ORIGINAL COMMITTEE	PRESENT COMMITTEE
Chairman	Carl P. Huber	Charles A. Hunter
Co-Chairman	C. O. McCormick, Sr.	William D. Ragan
Secretary	Verne K. Harvey, Jr.	Verne K. Harvey, Jr.
Committee Consultant	John Mackey Charles R. Mather Robert H. Oswald	William D. Ragan

TABLE 2

	ORIGINAL COMMITTEE	PRESENT COMMITTEE
Anesthesiologist:	Virgil K. Stoelting	Jerry Miller
Cardiologist:	W. Donald Close (Since the death of Dr. Close a new cardiologist has not been appointed.)	
General Practitioner:	Glen V. Ryan	(Vacant)
Internist:	William C. Bannon	William C. Bannon
Obstetrics and Gynecology:	David A. Bickel Charles F. Gillespie Elwood J. Meredith Mahlon F. Miller	Charles F. Gillespie Alfred H. Lampe Ora L. Marks Edgar L. Engel Gordon C. Cook
Pathologist:	Edwin B. Smith	Donald Hubbard
Urologist:	Robert A. Garrett	Daniel M. Newman

obstetrical and gynecological societies and local public health agencies.

All information is strictly confidential. Under no circumstance are any members of the family of the deceased interviewed. For purposes of study the puerperium has been defined to extend one year from the date of delivery. In this way deaths attributable to intercurrent disease compromised by or as the result of the pregnancy will not be missed. Before a case is reviewed by the committee, the attending physician is notified. The committee does not engage in any type of chastisement or disciplinary action.

Standards of reporting conform with national and international programs. Annual reports are made to the Indiana State Medical Association. The expenses of the committee are borne chiefly by the Indiana State Board of Health from federal formula grant funds.

Procedure

Death certificates with any obstetric factors involved are identified by the State Board of Health. When a number of cases confined to a geographic area are obtained, the secretary notifies the Committee Consultant, contacts the attending physicians and the hospital administrator, and arranges for an interview. In each case the Committee Consultant interviews the attending physician, reviews the hospital record and contacts the pathologist or any other pertinent consultants. He prepares a comprehensive summary covering the prenatal course, intrapartum, and postpartum phases of the pregnancy and circumstances of death for presentation before the committee. He records only facts and does not express an opinion. Information such as name and address of the patient, the name of the attending physician, name of the consultant, and the name of the hospital is treated as confidential. Presentation is made to the committee without personal case identification material.

The Maternal Mortality Commit-

tee meets two or three times each year, depending on the number of cases for consideration. The secretary provides each committee member with an unidentified summary of the case prepared by the Committee Consultant. Each case is reviewed from four viewpoints:

1. Is the death a maternal (obstetrical) death?
2. If so, is it a preventable or avoidable death?
3. If so, does the preventability rest with the patient, the doctor or the hospital?
4. Is the diagnosis on the Certificate of Death correct?

A discussion of the preventable factors is conducted by the chairman and the committee members. At the close of the discussion the committee voices its decision either by secret ballot or by consensus. The review of each death is systematic, wholly impersonal and completely objective. No report of the committee's opinion is sent to the attending physician involved unless he requests it. The attending physician is given the option to attend the meeting of the committee if he so desires. No attempt is made to criticize his skill or management of the case in question.

Future

Chapter 148, Acts of 1965 of the Indiana General Assembly, provided a new law for Indiana which protects (from subpoena) the information that is gathered by the committee and the committee's functions and decisions. It is hoped that with this law the information that is gathered can be used to a greater advantage to further decrease mortality as well as contribute to medical education.

A revision of the committee and its function was made in July 1972. A member of the staff of the Department of Obstetrics and Gynecology of the Indiana University School of Medicine has been assigned to work part-time on the maternal mortality cases. It is expected that this will make possible more efficient functioning of the

committee and that educational material and programs will be provided to the physicians in the state. The Maternal Mortality Study Committee will work closely with and coordinate its efforts with the newly formed Ad Hoc Maternal and Child Health Committee as well as the Marion County Perinatal Mortality Committee.

The following are among the goals which will be accomplished by the new committee structure.

A new method for gathering information has been completed. A mortality questionnaire will be sent to the attending physician prior to the Committee Consultant's visit which will reflect specific information and save the physician and Committee Consultant time. The pathologist will be contacted prior to the Committee Consultant's visit for a report or to at least assure that the microscopic sections of autopsies performed have been completed and are available for review. Copies of selected microscopic slides are requested and will be shown at the time of the case review by the committee. It is planned that selected interesting cases, along with discussion, will be published periodically in the Indiana State Medical Journal. A computer analysis of statistics is planned which will give a more detailed yearly report and provide more information with regard to the activities of the committee.

A Maternal Mortality Study and Educational Project has been set up which will involve obstetric residents and physicians. The long-term (three-year) evaluation of this project will proceed as follows:

1. Analyze demographic and management factors—age, parity, place of death, prenatal care factors, delivery and post-delivery factors, etc.
2. Develop criteria for identification in handling of the high-risk maternity patients.

3. Determine if maternal mortality is reduced.
4. Provide programs for hospital medical staff meetings and professional groups.

The obstetrician primarily responsible for this program will be available to meet with interested groups. It is hoped that in the future

the information gathered can be more fully used by professional persons, hospital medical staff meetings, interns, residents, and for student training. It is hoped that the physicians in the state who deal with obstetrics will profit from the new functions of the Indiana Maternal Mortality Study Program, and that preventable maternal deaths

will be eliminated.

1100 W. Michigan St.
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About Our Cover

A concerted effort is being made to preserve the history, documents and artifacts of the medical history of Indiana. A museum of Indiana Medical History is being developed in the Old Pathology Building on the grounds of Central State Hospital, Indianapolis, and the Indiana Historical Society is now publishing the **Indiana Medical History Quarterly**. These activities have been described previously in *The Journal*, and featured on the covers (*JISMA*, 64:9, 1971; 65:10, 1972, and 68:3, 1975).

Indiana University School of Medicine is also cooperating in this endeavor. Our cover shows some scenes from two motion pictures made by the Medical Education Resources Program of the school.

These films, both of which pertain to Indiana medical history, are now available. They may be purchased, or are available on loan at no charge within the state of Indiana for educational purposes. Those interested should contact the Medical Resources Program, Indiana University School of Medicine, 1100 West Michigan, Indianapolis 46202; phone 317-264-4083.—**Charles A. Bonsett, M.D.**

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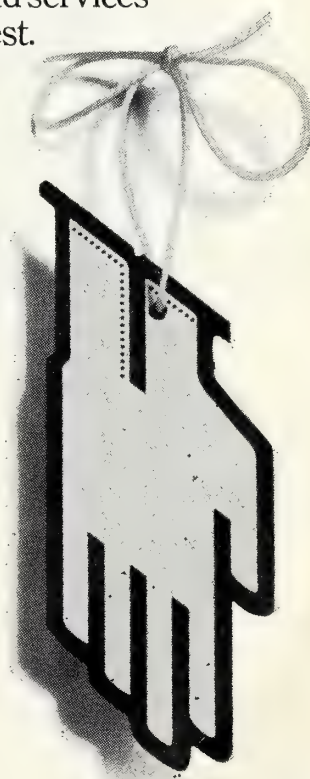
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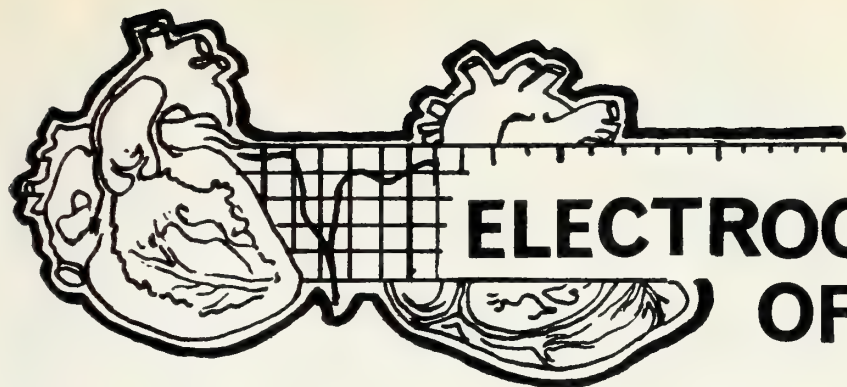
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ELECTROCARDIOGRAM OF THE MONTH

Atrioventricular Dissociation

JOHN C. BAILEY, M.D.
Indianapolis

ATRIOVENTRICULAR (AV) dissociation indicates that ventricular activation is independent of atrial activity. The term "AV dissociation" in no way is meant to imply a mechanism for failure of AV transmission. AV dissociation may be due to physiological refractoriness of AV pathways, so-called interference dissociation, or it may be due to a pathological state of AV pathways, AV dissociation due to block. AV dissociation, arising as a consequence of either mechanism, may be incomplete, indicating that successful AV transmission occurs some of the time, or complete, indicating that successful AV transmission never occurs.

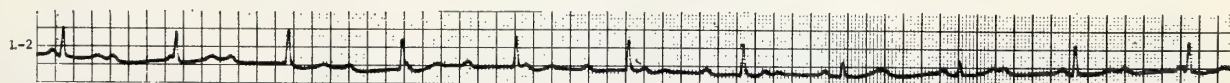
An example of complete AV dissociation due to interference is ventricular tachycardia without supraventricular capture beats. In this instance AV pathways and the ventricular muscle are rendered refractory to supraventricular capture because of the rapidity of ventricular discharge. Similarly, advanced degrees of AV dissociation may be due to rather trivial degrees of AV block.

In the tracings under discussion there is advanced AV dissociation, indicated by the independence of the QRS complexes from the P waves. Only the 8th and 9th QRS complexes are due to successful AV conduction (capture beats); the other QRS complexes are due to the escape of a junctional pacemaker. The mechanism for the two

captures is the occurrence of a P wave sufficiently late following the last junctional discharge so that AV refractoriness due to that discharge has dissipated. The T waves of the 8th and 9th QRS complexes are distorted by P waves of sinus origin, indicating the presence of 2:1 AV block, a minor degree of AV block. Following the two capture beats, AV transmission again fails because the junctional rhythm resumes before the preceding P wave has the opportunity to traverse the AV junction.

In summary, failure of AV transmission may not mean AV block. It is essential that one be able to distinguish between dissociation due to interference versus block, because the therapeutic and prognostic implication are entirely different. ◀

From the Krannert Institute of Cardiology, Marion County General Hospital, and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.



Advanced AV dissociation due to a minor degree of AV block.



1604 North Capitol Ave.
Indianapolis 46202

ENDOMETRIAL CARCINOMA AND ITS TREATMENT

Twenty-five outstanding national and international speakers will participate in the American Cancer Society, Kentucky Division, Cancer Conference on ENDOMETRIAL CARCINOMA AND ITS TREATMENT. Conference dates are Nov. 3 and 4 at the Galt House, Louisville. There is no registration fee. For complete information write: Dr. Laman A. Gray, Sr., Conference Chairman, Children's Foundation Building, 601 S. Floyd Street, Suite 407, Louisville, Ky. 40402.

* * *

REQUEST FOR PATIENTS FOR RESEARCH PROJECTS

Request #1

We (Indiana University School of Medicine) are presently engaged in research activity in conjunction with M. D. Anderson Hospital and Tumor Institute, Houston, evaluating BCG immunotherapy alone or in combination with chemotherapy for patients with poor risk malignant melanoma who are grossly free of disease. This would include any patient who has positive nodes following surgical node dissection, any patient with recurrent melanoma or any patient with metastatic melanoma beyond the regional lymph nodes who has undergone a surgical dissection and is grossly free of disease. I would appreciate being contacted concerning any such patients for possible entry to this study.

* * *

Request #2

We are currently engaged in a research project with M. D. Anderson Hospital and Tumor Institute in Houston, Texas, employing Adriamycin + Cytosin chemotherapy + BCG immunotherapy for any patient who has undergone a radical mastectomy within the past two months and had positive nodes at the time of mastectomy.

Preliminary data in a patient population having only four or more

positive nodes has produced very exciting results, with 48 or 50 patients being disease free at one year, and we are presently expanding the study. Because of these very positive results we are now including all patients with any number of positive nodes following radical or modified radical mastectomy. I would appreciate being contacted concerning any such patients for possible entry to this study.

LAWRENCE H. EINHORN, M.D.
1100 West Michigan,
Emerson 435
Indianapolis 46202
317-264-8229

* * *

LARYNGECTOMEE VISITATION PROGRAM

Over the past year, the Statewide Laryngectomy Committee, organized by the American Cancer Society, Indiana Division, Inc., has been developing a laryngectomy visitation program for Marion County. This pilot program, which parallels the nationally recognized Reach to Recovery visitation program for mastectomees, has been named SPEAK UP FOR RECOVERY.

As of June 1975, six laryngectomees who reside in Marion County are prepared to make patient visitations on the written request of a physician. Each volunteer visitor has (1) met strict speech, personal appearance and personality qualifications, (2) has been recommended for the program by his or her surgeon, and (3) successfully completed an eight-hour training course in technic and laryngectomy patient visitation.

The success as well as future state and national implementation of SPEAK UP FOR RECOVERY to a large degree will depend on physician utilization of the program. It is anticipated that a follow-up report on the success of this pilot program will appear in "Cancer Corner" in six months.

WILLIAM M. DUGAN, JR., M.D.
Chairman of
Professional Education,
Indiana Division
American Cancer Society, Inc.

SECOND ANNUAL CANCER SYMPOSIUM FOR THE PRIMARY CARE PHYSICIAN

When: October 1, 2, 3 and 4

Where: Inn of The Four Winds
Smithville, Indiana

What: Golfing, tennis, sailing, water skiing, swimming, fishing, hiking, superb dining AND a cancer seminar for the practicing physician. Emphasis of the program will be on practical aspects of diagnosis and treatment of cancer. The three-day program will be jointly sponsored by the Indiana Division of the American Cancer Society and the Department of Medical Education, Methodist Hospital Graduate Medical Center, Indianapolis. Speakers include specialists in cancer diagnosis and treatment. For a complete description of the program contents refer to the August issue of THE JOURNAL.

For a program brochure and registration cards for the seminar and room accommodations, clip and mail coupon to

Dr. William M. Dugan, Jr.
Methodist Hospital Department
of Medical Research

Please send program information
and registration cards for the
Cancer Symposium to:

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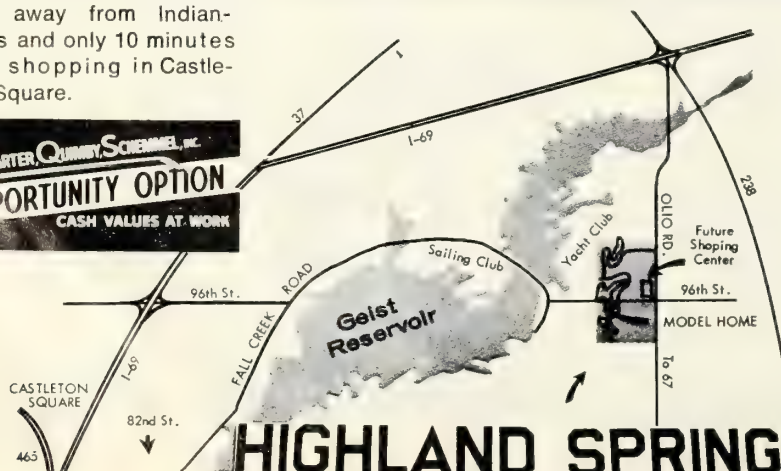
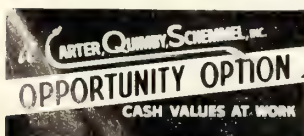


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Guest Editorial

The Example of New York

CONSIDERING the troubled state of New York City's finances, the temptation is great for non-New Yorkers to draw on a glittering cloak of self-righteousness and berate the Big Apple for its many failings.

But yielding to that temptation would be very foolish. The problems of New York are not unique. The entire country is making the same mistakes that have led the city to the brink of bankruptcy.

What happened? Very simply, the citizens of New York, collectively, have long demanded more from the city in services than they were willing (or able) to pay for. The city politicians—loath to say “no” to the voters—took the “easy” way out and borrowed to cover the gap between income and outgo.

A city, a company, or a country can get away with such borrowing when its prospects are good, when it is growing in prosperity so rapidly that lenders believe their loans can easily be repaid.

But the upward spiral has a down side, too. When debt has grown in anticipation of future economic growth, and the economic growth doesn't come, things start to go wrong fast: Taxes must be raised and new loans floated to meet payments on old loans.

Ultimately, a city or a company may reach a point in such a cycle where there are no lenders willing to risk their money. Then, it either defaults on its debts and goes into bankruptcy or it takes whatever drastic, painful economy measures are necessary to restore its good credit rating.

A country does not have the problem—or the benefit—of flinty-hearted creditors who finally draw the line. A country can pay for its profligacy by levying on its citizens the hidden tax of inflation, because a country has the ability to create new money. But inflation, too, takes its toll.

So now we're in a bad national recession. And we're being told the way out is for the national government to go deeper into debt, to print more money.

A moderate level of deficit spending for a brief period is nothing to get alarmed about—and certainly justified insofar as it is used to care for the unemployed until the economy gets back on the track. But the enormous deficits Congress is happily contemplating are not the road to recovery—they are the road to New York.—**Richard L. Leshner, president, Chamber of Commerce of the United States.**

Editorial Notes . . .

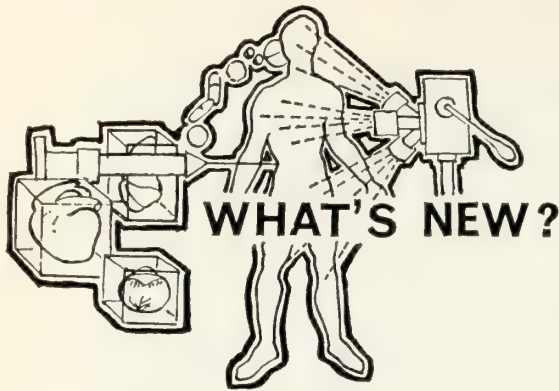
Upjohn's “Guidelines to Profes-

sional Pharmacy” has an article on the dangers of drug interactions in patients taking anticancer agents. Aspirin, alcohol, tranquilizers, sedatives and foods such as wine, cheese and chicken livers are suspected of producing severe interactions. Dr. Martin Apple says that such interactions may increase the blood level of anticancer drugs or prolong and intensify their effects.

The FDA has issued new restrictions for the clinical investigation of chymopapain, the controversial substance sometimes used to treat damaged intervertebral discs. It has been under study since 1963 but recently double-blind studies indicate that it may not be any more effective than a placebo.

A U.S. District Court has ruled that FDA cannot continue with the regulation that “me-too” drugs may be marketed without an approved new drug application. The decision will place in jeopardy the FDA rules for the administration of the maximum allowable cost scheme.

The VA has been observing the effects of alcohol on epileptics. Consumption of alcohol can increase the frequency of seizures by as much as 85%. Worsening of seizures varied directly with increased frequency and quantity of alcohol consumed. ◀



Lederle announces Aristocort® in ointment form. ARISTOCORT A Ointment 0.1% is completely dissolved in a propylene glycol base; in the 0.5% ointment it is partially dissolved. The ointment is non-greasy and washes off with soap and water.

* * *

Chemical Dynamics has a new device which generates light without heat or flame. It will illuminate an average room. It consists of a plastic tube containing two sealed liquids which when mixed together by bending the tube will produce a yellow-green light for three hours, plus an additional 8 to 10 hours as a marker light. It is safe to use in the presence of flammable or explosive substances.

* * *

Acculab announces a new booklet describing the fastest and most reliable method of separating and filtering blood serum. The device does not introduce any foreign chemicals but removes fibrin clots and all particulate matter. It consists of a piston which contains a microfilter and which fits exactly inside the glass tube containing centrifuged blood. When pushed down into the serum the filter allows only serum to pass, so that the clean serum ends up on top of the piston and the clot and particulate matter below.

* * *

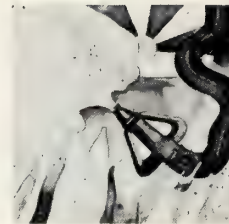
General Scientific Equipment has a pain killer in an aerosol can. Called G-63, one spray isolates the affected area with an invisible protective film. Recommended for scratches and superficial burns.

* * *

EL Lilly's new antibiotic, Nebcin® (tobramycin sulfate, Lilly), is a clear, colorless sterile aqueous solution that does not require refrigeration. It may be given intramuscularly or intravenously. Dose for adults, infants and children with normal renal function is 3 mg/kg/day, in three doses.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.



Pro-Banthine®
brand of
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Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control.

For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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Address medical inquiries to: G. D. Searle & Co.
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"Antiacid" action — Pro-Banthine® (propantheline bromide) reduces gastric secretory volume and resting total and free acid.

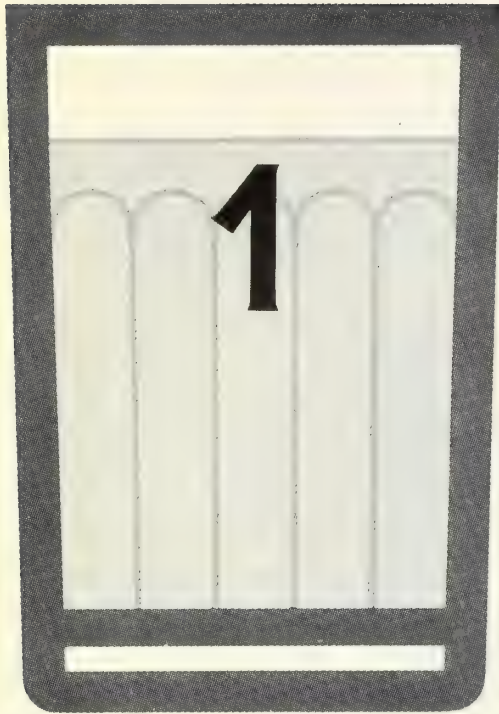
"Analgesic" action — Pro-Banthine helps to control the acid-spasm-pain complex.

Vigorous anticholinergic action — Pro-Banthine® Vials, 30 mg., are for intramuscular or intravenous use when prompt and vigorous anticholinergic action is required.

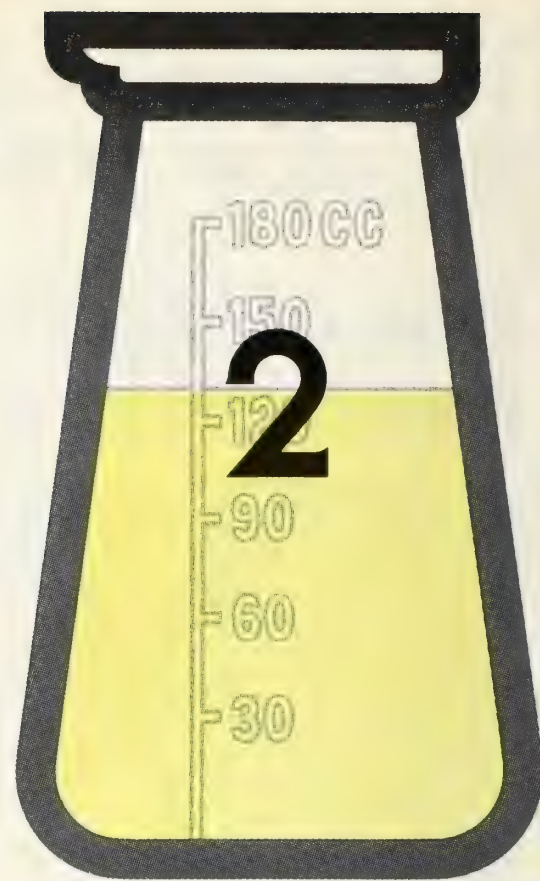
Mild anticholinergic action — Pro-Banthine® Half Strength, 7.5 mg. tablets, for more exact adjustment of maintenance dosage in mild to moderate gastrointestinal disorders.

Pro-Banthine® (propantheline bromide)

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option
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**Adequate
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**Frequent
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Gantanol[®] (sulfamethoxazole) B.I.D.

Four tablets (0.5 Gm each) STAT-
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Basic therapy with
convenience for
acute nonobstructed
cystitis

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic non-obstructed urinary tract infections (primarily pyelonephritis, pyelitis, and cystitis) due to susceptible organisms. **Note:** Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials, including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprotrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, peri-orbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.



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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

• Effective against susceptible *E. coli*,
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makes sense

Each capsule contains 50 mg. of Dyrenium[®] (brand of triamterene) and 25 mg. of hydrochlorothiazide.



For long-term control of hypertension*

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* WARNING

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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Subsidiary of SmithKline Corporation

'DYAZIDE'

Just once or twice daily for maintenance.
Hydrochlorothiazide to help keep
blood pressure down and triamterene
to help keep potassium levels up.



CURRENT SURGICAL DIAGNOSIS AND TREATMENT

J. Englebert Dunphy, M.D., Professor of Surgery, and Chairman, Department of Surgery, University of California School of Medicine (San Francisco) and Lawrence W. Way, M.D., Associate Professor of Surgery, same university, and associate authors, Lange Medical Publications, Los Altos, California, 1975; illustrated by Laurel V. Schaubert; second edition; 1093 pages plus 29-page appendix and index; \$15.00. The work is being translated into Spanish, Italian, German, Japanese, Portuguese and Serbo-Croatian.

The authors and publishers are certainly men of their word, since it was stated in the first edition (1973) that "a second edition will appear within two years." Changes made include consolidation of separate chapters on trauma into one, and the "chapters on shock, the pancreas, the large intestine, venous diseases, the thyroid and parathyroid, hernias, the biliary tract, and hand surgery have been extensively revised or completely rewritten." New illustrations have been added. In review of the first edition it was noted that the book is "remarkably homogeneous, considering the fact of 62 different authors. However, all but eight are from the University of California School of Medicine (San Francisco) . . . the 'home base' of Doctors Dunphy and Way." For the second edition there are 70 authors, all except seven from San Francisco, and two of these are from Palo Alto (Stanford University).

The book is well organized in the same pattern as before, and at the top of each page is a line giving the chapter number and its title, or subject. This greatly facilitates cross-reference during study of any particular subject, and could be adopted by all publishers with great profit to the reader.

Format is soft cover (plastic) as before, much easier to hold, while reading, than a hard cover—especially appreciated in a book weighing 4½ lbs. Typography and illustrations are as before: excellent. Very few typographical or spelling errors have been noted. This is a book for medical student and practitioner alike. The increase in price is 7.1%.

A. W. CAVINS, M.D.
Terre Haute

ACUTE AORTIC DISSECTIONS

C. E. Anagnostopoulos, M.D., University Park Press, Baltimore, 1975; 253 pages with numerous plates and diagrams; \$24.50.

Even in these days of inflation, the price of this rather slim volume seems rather steep but the fresh and up-to-the-minute discussions more than make up for this. The foreword by the world famous Norman E. Shumway immediately sets the tone for the whole opus.

This great pioneer of cardiac surgery says: "Acute dissection of the aorta is a surgical emergency. This disease has long been misdiagnosed, misunderstood and frequently misrepresent-

ed. Previously, known as 'dissecting aneurysm of the aorta' but now more accurately referred to as 'acute dissection of the aorta.' . . . Emergency surgery is the best hope."

This important work should be read by every physician who treats patients with chest pain—particularly cardiologists, internists and cardiac surgeons, as well as by pathologists and radiologists who deal with hypertension. But every library must have this on its reference shelves. Hopefully, it will bring us all up to date on the treatment of a condition now revealed as being treatable. Let there be no dilly-dallying or shilly shallying!

ARNOLD LIEBERMAN, M.D.
New York City

PEDIATRIC NEPHROLOGY

Pierre Royer, M.D., editor, Anthony Walsh, F.R.C.S.I., translator, W. B. Saunders Company, Philadelphia, 1974; 454 pages; \$19.00.

Any physician who is unaware of the advances in clinical nephrology since the subspecialty came of age with the development of the percutaneous renal biopsy in the 1950s, will be disabused of his ignorance by reading this volume. There is a remarkable range of knowledge relating to childhood medical diseases of the kidney and Dr. Royer and his associates from the Hospital des Enfants Malades of Paris have seemingly omitted nothing in this comprehensive survey.

It is divided into four parts—from congenital diseases through infections and glomerulopathies to renal failure and hypertension. There are four authors including the editor and the book is really a well-knit symposium. The usual opprobrium of disjointedness doesn't apply here in spite of the multiple authors, possibly because, as Dr. Royer states in his preface, they have worked together clinically for 15 years and have a commonality of view. As a clinician myself, I found the chapters on treatment of urinary infection, acute and chronic renal failure and glomerular disease especially rewarding. It is no criticism to say that some of the concepts related here are of considerable complexity and are beyond full comprehension, at least in some measure, without an extensive background in internal medicine.

The excellent English text was provided by the well known genitourinary surgeon of Dublin, Ireland, Mr. Anthony Walsh. I could find practically no Gallicisms creeping through the translation and his job is commendable.

All in all, highly recommended reading for urologists, internists and pediatricians of every description.

RODNEY A. MANNION, M.D.
LaPorte

THE STRUCTURE AND FUNCTION OF CHROMATIN

Ciba Foundation Symposium #28 (new series), David W. Fitzimons and G.E.W. Wolstenholme, editors, American Elsevier Publishing Co., New York, 1975; 378 pages with more than two dozen participants; \$29.50.

This is another, rather noteworthy, addition to the proliferating publications in this field. The electron microscope and various recently developed other scanning devices are beginning to give us a new perspective into a very moot field. Of course, we know (now) that chromatin is the very warp and woof of making up the chromosomes that determine ever-so-precisely the nature of each living creature. In this monograph, the authors explore the specific aminoacids of which the chromosomes are composed; the percentages, the exact sequences in spaces and what they seem to do.

Continued

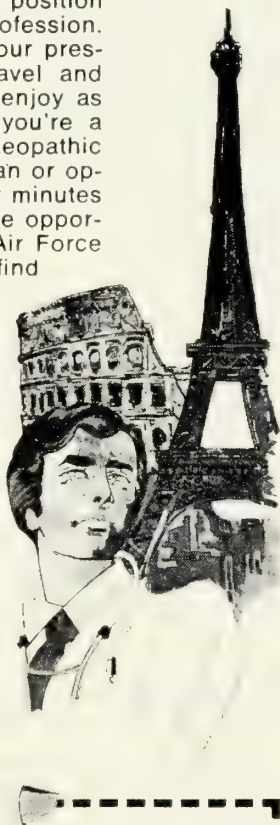
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ABSTRACTS, BOOKS

Continued

This is a volume meant for the specialist and—by its very nature—is an evanescent statement of just what is up to date in this field. The binding, printing and paper are up to their usual superb standards. Expensive but just what the specialist wants.

ARNOLD LIEBERMAN, M.D.
New York City

THROMBOEMBOLISM—ETIOLOGY, ADVANCES IN PREVENTION AND MANAGEMENT

A. N. Nicolaides, M.B., F.R.C.S., editor, University Park Press, Baltimore, 1975; 348 pages with numerous tables, illustrations and figures; \$29.50.

Along with some twoscore associates, the editor has done a really painstaking chore in elaborating on the stated topic. The references are profuse; each chapter closes with a down-to-earth summation. The paper, binding and printing cannot be faulted.

As an American provincial, I am somewhat baffled by the absence of any reference to *Peripheral Vascular Disease*, originally authored by Allen, Barker and Hines and presently in its fourth edition under the aegis of Fairbairn, Juergens and Spittell. In my corner of the ring, this has been the definitive text in this field. Were Professor Nicolaides to scan this monograph, I do believe he and his cohorts would find some interesting material.

Be that as it may, this is an excellent opus worthy of a place on the desks of many physicians specializing in this field. The paper, binding and printing are excellent. The reading is easy, even for medical students. I do think that hospital librarians should consider buying this for their shelves.

ARNOLD LIEBERMAN, M.D.
New York City

THE FUTURE OF PHILANTHROPIC FOUNDATIONS

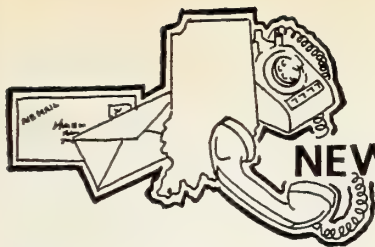
Ciba Foundation Symposium No. 30 (New Series) held jointly with the Josiah Macy Jr. Foundation; American Elsevier Publishing Co., New York City, 1975; edited by G. E. W. Wolstenholme; 240 pages; \$27.50.

More than a dozen distinguished participants discuss the functioning and role on the contemporary scene of such well known groups as the Rockefeller, Ford, Nuffield, Nobel, Van Leer, Wellcome and other trusts.

Just what can these foundations do to aid the developing countries? Guide research projects all over the world? What are their moral and social responsibilities? What priorities should show the way to their trustees? Professor Bell of Harvard speculates on the next 25 years; Professor Goheen has some thoughts anent the "Jeffersonian potential"; what is the role of a foundation set up by the government? And so on and so forth. All in all, a symposium that answers none of the questions being raised so intriguingly.

As always, the paper, printing and binding are superb; there was an unusual number of typographical errors. Public libraries will want this on their shelves. Hospital administrators should be urged to scan these pages. This is *not* a run of the mill effort!

ARNOLD LIEBERMAN, M.D.
New York City



NEWS NOTES

Geriatrics Teaching Program Featured

The *Evansville Courier-Press*, in its Sunday "Home and Family" Section on July 13, highlighted with pictures and text the home for oldsters which is the facility of Little Sisters of the Poor. One of the highlights is the medical service organized by **Dr. Herman Baker**, who has developed a geriatrics teaching program. Bill Montrastelle, director of therapy at Welborn Hospital, supervises the physical therapy and rehabilitation program.

Cancer Society Grant to I.U. \$30,000

Dr. George Weber, Chairman of the Institutional Research Grant Committee of Indiana University School of Medicine, will administer a \$30,000 grant from the American Cancer Society. The subjects for research will include study of biochemistry, tissue culture and behavior of cells and viruses.

Medical Assisting Program Accredited

Indiana Vocational Technical College, 510 Spring Street, Jeffersonville 47130, has been granted accreditation of its medical assisting program by the Council of Medical Education of the American Medical Association, in collaboration with the American Association of Medical Assistants.

Graduates of the program will receive a one-year certificate. Sylvia McCurdy, R.N., is Director of Health Occupations.

The Indiana Vocational Technical College program provides a basic knowledge of anatomy, physiology, medical terminology, medical law and ethics, human relations, bookkeeping, insurance, administrative, laboratory and clinical procedures.

Dr. Suelzer Receives ACEP Award

At the recent national convention of the Society for Total Emergency Preparedness, **Dr. John G. Suelzer, Indianapolis**, received the top award of the Indiana Chapter of the American College of Emergency Physicians. He was credited with creating a model program for emergency medical services that is used in hospitals throughout the nation.

New Films Offered by Eaton

Eaton Laboratories has added new films and new sound slide programs to its medical-surgical film library. One film is "Self-Examination of the Testes for Testicular Tumor." Other films deal with exstrophy, inguinal hernia, Meckel's diverticulum, and ureterosigmoidostomy. Arrangements may be made to borrow any films or slide programs in the Eaton Library by a request to an Eaton sales representative or by writing the firm at Norwich, N.Y. 13815.

Governor Bowen Addresses Parley

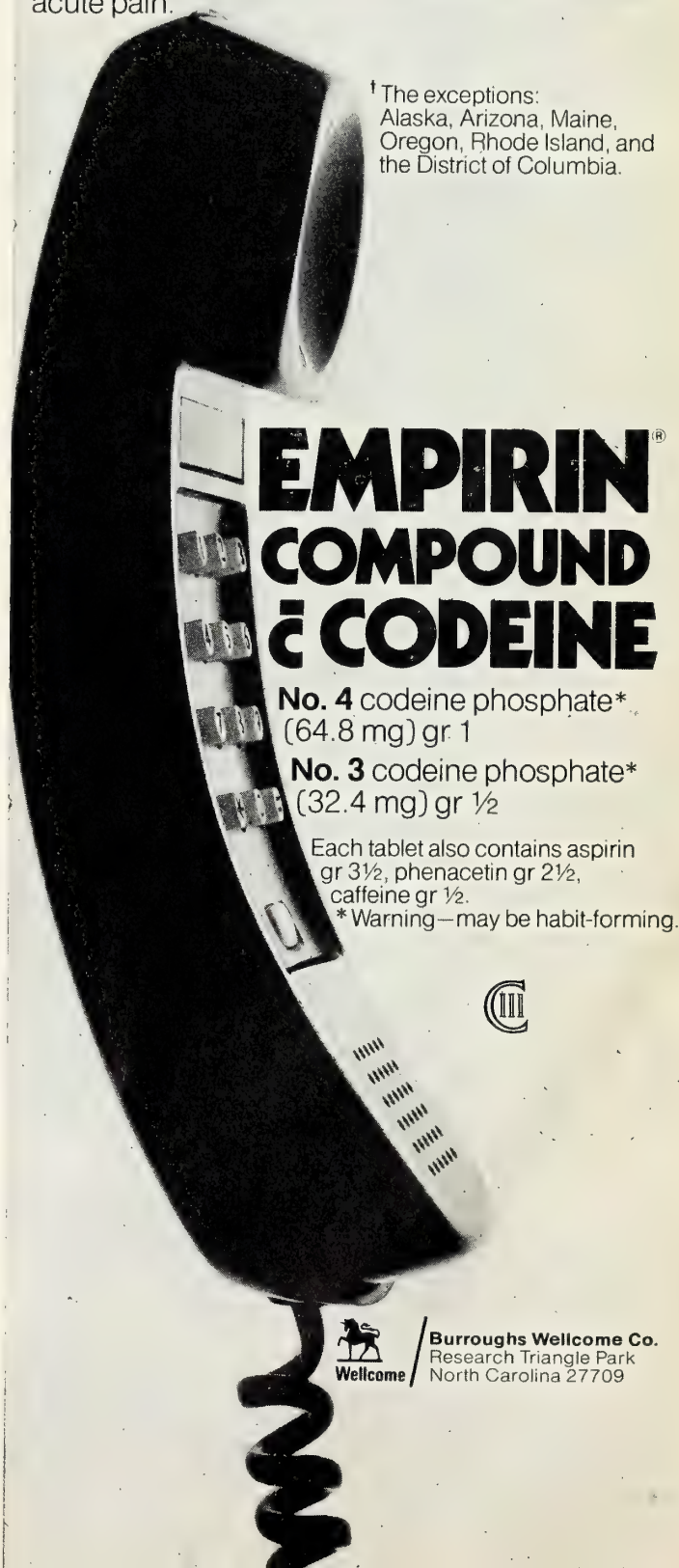
Governor Otis R. Bowen was one of the featured speakers at the American Medico-Legal Institute's seminar on "Malpractice—Self Defense '75," held at Las Vegas, Nev., Aug. 11-14.

Continued

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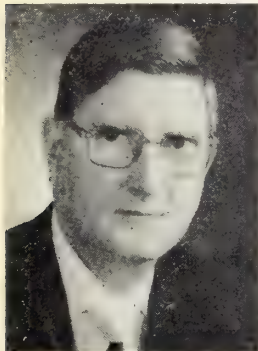
* Warning—may be habit-forming.



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Dr. Steen Elected AMA Trustee

Dr. Lowell J. Steen, Hammond, a past-president of the Indiana State Medical Association (1969-70), was elected a trustee of the American Medical Association at the Annual Convention at Atlantic City. He will serve one year, completing the unexpired term of Dr. Richard E. Palmer, who was named president-elect.



An internist, Dr. Steen started in private practice in 1953 and has participated actively in organized medicine ever since. A Fellow of the American College of Physicians, he served as president of the Indiana Chapter of the American Society of Internal Medicine in 1962. Dr. Steen had his original military service as

surgeon of the 25th Division Artillery in 1949-50. Later, in 1955-56, he was chief of the Medical Service of the U. S. Army Hospital at Salzburg, Austria.

Dr. Lee Cattell Heads Division

Dr. Lee M. Cattell, Jr., Indianapolis, has been appointed Medical Director of the Utilization Review Division of Blue Cross/Blue Shield.

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Article Debunks "Health Care Crisis"

"Government Can Be Hazardous to Your Health" is a truthful statement. It is also the title of an article by M. Stanton Evans which has been printed by IMPRIMIS, the journal of The Center for Constructive Alternatives, of Hillsdale College, Hillsdale, Mich. Mr. Evans debunks the "health care crisis," the "doctor shortage" and many other myths which are used to embarrass the medical profession. Single copies of the article may be obtained free by writing the College. Quantities are sold at reasonable rates.

Dr. Brockmole Reappointed

Dr. Arnold W. Brockmole, Evansville, was recently reappointed to membership on the Health Facilities Council by Governor Otis Bowen.

Dr. Thomas Honored by March of Dimes

Dr. Charles Thomas, Indianapolis, was one of those honored at the annual volunteer recognition program of the Central Indiana Chapter of the National Foundation—March of Dimes recently. He served as cochairman of the Central Indiana Action Conference on the Quality of Life.

Featured speaker for the program was **Dr. Sprague H. Gardiner**, chairman of the National Committee on Perinatal Health.

Top Science Student Wins Roche Award

Dean Felker, of Corydon, received the Roche Pharmaceutical Company Award as the top student in the basic sciences at I.U. School of Medicine. The award, a gold Omega wrist watch, was presented by Dean Beering, for whom the event was nostalgic. The dean was one of the recipients of the award when he was a student at Pittsburgh 25 years ago.

President Wilhelmus Addresses King County Medical Society

President Gilbert M. Wilhelmus continues to spread the word around the nation to state and county medical societies on Indiana's "Patient's Compensation Act." He appeared before the King County Medical Society, Seattle, Wash., in July to discuss the Act and the activities of ISMA in accomplishing its passage.

Physicians Make \$150,000 Gift to I. U. School of Medicine

The trust committee of the Indiana Medical Education Foundation, representing Hoosier physicians, recently granted \$125,000 to the Indiana University School of Medicine.

Since its organization in 1953, the foundation has given more than \$925,000 to the School of Medicine. The funds are derived from investments of the trust and contributions by Hoosier physicians and their wives.

In expressing gratitude for the continued support from the foundation, School of Medicine Dean Steven C. Beering emphasized that the money this year will be used primarily to develop the urgent needs of the new Department of Family Medicine.

The foundation is organized to represent both the School of Medicine and the Indiana State Medical Association. The 12-member trust committee is chaired by **Dr. Donald E. Wood of Indianapolis**.

Dr. Paynter Commissioned Agent for FDA

Dr. William T. Paynter, Indiana health commissioner, has been commissioned by Donald C. Healtion, Region V food and drug director for the United States Food and Drug Administration, to serve as an agent for the FDA.

Dr. Paynter's responsibilities will include authorizing programs necessary for the regulation of interstate shipments of food and drugs. The commissioning of state officials by the FDA represents a decentralization of FDA controls, he said.

Wine Institute Offers Booklet

The Wine Advisory Board of the State of California announces release of a revised and updated edition of the booklet "Uses of Wine in Medical Practice." For a copy write to Wine Institute, 165 Post St., San Francisco 94108.

Dr. Havens Memorial Fund Set Up

Friends have established the **Dr. Oscar D. Havens** Memorial Fund to collect money to purchase a tangible gift of laboratory equipment for Riverview Hospital, Noblesville. Dr. Havens died suddenly last March at the age of 60.

Film on Medical Thermography Offered

Medical Thermography is covered comprehensively in a 24-minute film which covers a wide variety of its uses in medicine. The detection of cancer of the breast, diagnosis of inflammation, deep vein thrombosis, its use in peripheral vascular disease and in screening for stroke, are included. The film may be rented from AGA Corporation, 550 County Ave., Secaucus, N.J. 07094.

Dr. Stander to Ob-Gyn College

Dr. Richard W. Stander, at one time a member of the Ob-Gyn faculty of I.U. School of Medicine, and recently Director of the Department of Obstetrics and Gynecology at the University of Cincinnati, has joined the national office administration of the American College of Obstetrics and Gynecology in Chicago, where he will be Director of Education.

Malignant Melanoma Patients Sought

The National Cancer Institute is seeking referral of patients with suspected or diagnosed malignant melanoma which has not spread beyond regional lymph nodes. There is no charge for treatment at the NCI. Write to William D. Terry, M.D., National Cancer Institute, Bethesda, Md. 20014.

Ames Company Has Traveling Road Show

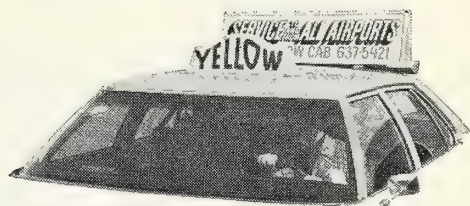
The Ames Company of Elkhart has a road show—a mobile van unit with displays of hospital equipment and supplies. The van makes three to four tours per year on an appointment schedule. The two sales specialists are able to display and demonstrate their wares without upsetting hospital routine and without the bother of unloading and reloading. The van is equipped with living quarters for the sales force. Efficient too—with the van they can call on 50 customers per week.

Named to Head Perinatal Center

Dr. William T. Weathers, Evansville, who has been with the Mead Johnson Research Center as senior clinical investigator since 1973, has been named a director for pediatric education and of the perinatal center at St. Mary's Hospital, Evansville.

Continued

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News Notes

Continued

"Surgery Grand Rounds" to Be Televised

Surgeons at Indiana University School of Medicine will conduct a monthly "Surgery Grand Rounds" for hospitals on the live WAT 21 Medical Television network beginning Oct. 1. The second presentation will be on Nov. 5. Such subjects as duodenal ulcer, pigmented skin lesions, breast carcinoma, thyroid disease, infant surgery and urological disorders will be covered at various times this fall and during the winter. Viewers are urged to write in or call to make suggestions for content and format as the series progresses. "Surgery Grand Rounds" is accredited by the AAFP, the ACP (Osteopathic), and the AMA.

Psychiatric Center Elects Dr. Cabrera

Dr. Juan C. Cabrera, Evansville, was recently elected president of the medical staff at the Evansville Psychiatric Children's Center, and Dr. Joseph E. Coleman was elected secretary-treasurer.

Evaluation, Management Center for Sickle Cell Disease at Riley Hospital

The Division of Pediatric Hematology-Oncology at the James Whitcomb Riley Hospital for Children has established a statewide comprehensive evaluation center and management unit for Indiana children and young adults with Sickle Cell Disease. This unit will work closely with the Indianapolis Sickle Cell Anemia Foundation and all other facilities or agencies in the state that are involved in Sickle Cell Disease and will accept patient referrals from such facilities and from physicians in the state. The entire medical and allied health staff for the James Whitcomb Riley Hospital for Children will be available for consultation in regard to the problems experienced by these patients.

Requests for such referrals should be made to the Division office at Riley Hospital, Indianapolis.

Scholarships Honor Dr. LaFollette

The Dr. Donald R. LaFollette Memorial Scholarship for entering freshmen at Indiana University Southwest has been established.

The Indiana University Foundation will administer the scholarship to a graduating student at Floyd Central or New Albany high schools in memory of Dr. LaFollette, a New Albany physician who died in May.

Two Elected by Pediatric Academy

Two Northwest Indiana physicians have been elected to fellowship in the American Academy of Pediatrics. They are Dr. Douge Barthelemy, Gary, and Dr. Mervin C. Stover, III, Munster.

St. Joseph Medical Society Moves

Offices of the St. Joseph County Medical Society are now located at 2015 Western Avenue, South Bend, to better serve its 240 members and the people of the area. The society's telephone number remains the same.

The physicians of St. Joseph County were first organized into a society in 1855, according to Dr. Louis F. Sandock, president, and the society was officially chartered by the Indiana State Medical Association on July 14, 1903.

Public Opinion Wires for Only \$2

Citizens can make themselves heard when it counts for only \$2 per telegram in the continental United States by using a special Western Union "Public Opinion Rate." Fifteen words are allowed in the text, exclusive of the address and signature. This message will be written on the familiar yellow form and will be delivered by Western Union. (Western Union also offers a Mailgram for \$2, which allows 100 words including the address and signature, but it is delivered the next day by the Post Office.)

In *Wolf Sanctuary News*, a publication of preservationists concerned with endangered species, George Pappard, star of *Banacek*, is credited with "discovery" of this 15-word rate. He has written and appeared in TV film spots to publicize this method of speaking up on issues. One senatorial staffer told him: "Telegrams are given precedence because they are legible, brief and immediate. The recipient knows the sender felt strongly enough to spend his money to be heard."

If you send a telegram to your senator or congressman, be sure to ask for the special Public Opinion Rate. Normally it would cost \$5.85 for a 15-word wire from Los Angeles to Washington.—*MD's WIFE*, May 1975.

National Cancer Institute Seeks Soft Tissue, Boney Sarcoma Patients

The National Cancer Institute is seeking referral of patients with primary soft tissue or boney sarcomas. Such patients will not be charged for medical care at the NCI. Write Steven A. Rosenberg, M.D., National Cancer Institute, Bldg. 10, Room 10N116, Bethesda, Md. 20014.

Dr. Black Wins Trustee Election

Dr. Joseph M. Black, Seymour, defeated three other candidates to win reelection to the Board of Trustees of Indiana University recently. He received a total of 10,420 votes out of the 24,059 ballots cast.

Dr. Black has completed one three-year term on the Board, is former national president of the I.U. Alumni Association and former president of the Indiana State Medical Association. He is serving his fifth term on the board of directors of Indiana Blue Shield.

Juvenile Diabetes Foundation Offers Postdoctoral Fellowships

Applications for postdoctoral fellowships of the Juvenile Diabetes Foundation may be made now for the 1976-77 year. Deadline for applications is Sept. 26. Applications may be obtained from Shel Sukoff, Juvenile Diabetes Foundation, 23 E. 26th St., New York City 10010, or call (212) 689-7868. Those selected will be notified early in 1976 and funding will begin July 1, 1976.

Dow Completes Lab Expansion For Toxicology Research

Dow Chemical has completed a laboratory expansion at Midland, Mich., to accommodate research in industrial toxicology. The goal is to develop information to provide for safe manufacture, handling, use and disposal of chemicals, such as pharmaceuticals, food additives, pesticides, food packaging materials, and all those chemicals suspected of producing cancer.

New Licensing Board Takes Up Duties

Members of the Medical Licensing Board of Indiana, appointed by Governor Otis R. Bowen following the resignation of all members of the previous Board, were sworn into office on Aug. 6. They are: **Ernest R. Beaver, M.D., Rensselaer**; **Walter J. Beneville, D.C., Jeffersonville**; **Bruce C. Brink, D.O., Princeton**; **James N. Hampton, M.D., Argos**; **Edward L. Hollenberg, M.D., Winamac**; **Robert R. Kopecky, M.D., Indianapolis**, and **John H. Mader, M.D., Richmond**.

Officers were elected at the Board's first meeting, as follows: President, Dr. Beaver; vice-president, Dr. Hampton; secretary, Dr. Kopecky; treasurer, Dr. Mader.

Hospital Medical Staff Elects

Dr. Richard P. Auburn, Munster, has been elected president of the medical staff of Community Hospital in Munster. **Dr. Robert L. Young**, also of Munster, was named to the vice presidency, and **Dr. Carlos A. Serna, Highland**, will serve as secretary-treasurer.

Veterinarians Elect Hoosier President

Dr. Harry J. Magrane, a small animal practitioner from Mishawaka, assumed the presidency of the American Veterinary Medical Association in July. He has practiced in Mishawaka since 1946 and had the honor of having his hospital designated as "Hospital of the Year" in 1972 by Veterinary Economics Magazine.

Receives Approval of Residency

The Deaconess Hospital of Evansville has received approval of a three-year family practice residency. Four doctors can be accepted into the program each year.



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The Woman's Auxiliary Reports to ISMA



Our guest contributor this month is Mrs. John R. Stanley, of Muncie, first vice-president and membership chairman.

Allie L. Reed

Mrs. Edsel S. Reed
President

Membership

In my association with the Medical Auxiliary over the past several years, I have watched it become increasingly more concerned for the general well-being of all people. In many communities, the auxiliary members have initiated programs for family health needs.

The medical profession faces a serious crisis. We, as doctors' spouses, can help by being well informed on all the issues. One way you can be informed is through the auxiliary. It is our job, as public relation representatives for our doctor husbands, to tell the health care story as it is. We can accomplish a lot if we all work together. Start by calling the new doctors' wife, or interns' and residents' wives, and welcome them to your community. Also ask them to go with you to an auxiliary meeting. If you live in an area which does not have an auxiliary, there is even more reason for you to call the other doctors' wives to get together. BE a member-at-large. As we start our new auxiliary year let each one of us contribute our talents and ideas for a combined successful effort.

It is hoped that all doctors in Indiana will encourage their spouses to become auxiliary members.

I am really looking forward to the State Convention at French Lick and meeting many of you there.

MARY K. STANLEY
(Mrs. John R. Stanley)
First Vice-president



Natural balance doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

Found useful in the management of vertigo* associated with diseases affecting the vestibular system.

Can relieve nausea and vomiting often associated with vertigo.*

Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.

Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.

Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."


ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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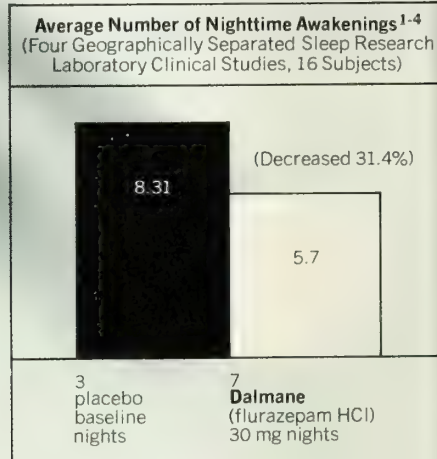
Antivert[®]/25 (meclizine HCl) 25 mg. Tablets for vertigo*



Would sleep with fewer nighttime awakenings benefit your patients with insomnia?

Highly predictable results for your patients with trouble staying asleep...

...can be obtained with Dalmane (flurazepam HCl). As shown below, Dalmane significantly reduces nighttime awakenings:¹⁻⁴



And for those with trouble falling asleep or sleeping long enough...

...Dalmane (flurazepam HCl) also delivers excellent results. Clinically proven in sleep research laboratory studies: on average, sleep within 17 minutes that lasts to 8 hours.⁵

Dalmane (flurazepam HCl) is relatively safe, seldom causes morning "hang-over"...

...and is well tolerated. The usual adult dosage is 30 mg *h.s.*, but with elderly and debilitated patients, limit the initial dose to 15 mg to preclude oversedation, dizziness or ataxia. Evaluation of possible risks is advised before prescribing.

REFERENCES:

Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971

Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 44th annual Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971

Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly

or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

Depend on highly predictable results with

Dalmane[®]
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage (15 mg may suffice in some patients).

One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

specifically indicated for insomnia

Objectively proved in the sleep research laboratory:

- sleep with fewer nighttime awakenings
- sleep within 17 minutes, on average
- sleep for 7 to 8 hours, on average, with a single *h.s.* dose.



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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association



The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

Opinion
&
Dialogue

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



President's Page



State Convention

We, the leadership of the Indiana State Medical Association, have attempted to contract the State Convention into a three-day program—making it short, but dynamic. I felt that the State Convention has always been unnecessarily long. Thanks to the Convention Arrangements Committee (Tom Spain, M.D., chairman) and the Sports Committee (Brad Bomba, M.D., chairman), this meeting promises to be interesting, informative and educational.

Some of the highlights of the Convention are:

- ★ House of Delegates meetings—Monday, Oct. 20, 1975 and Wednesday, Oct. 22, 1975.
- ★ The Speciality Societies are having educational forums which give postgraduate education credit.
- ★ Social events—outstanding speakers will be David Frost and David Hoy, with a special highlight "The Singing Doctors" from my own home town in Evansville.
- ★ Sports seminars—featuring Bobby Knight, Pinky Newell, Don Cooper, etc.
- ★ And the French Lick Hotel—an outstanding resort with everything available for your pleasure—golf courses, tennis courts, riding trails, bowling, swimming—and don't forget the famous baths!

Remember the dates—Oct. 20, 21 and 22—at the French Lick Sheraton Hotel in beautiful Southern Indiana.

SEE YOU IN FRENCH LICK ! ! !

A handwritten signature in dark ink, appearing to read "Gilbert M. Wilhelmus". The signature is stylized with a large, looping initial "G" and a long, sweeping underline.

Gilbert M. Wilhelmus, M. D.
President
Indiana State Medical Association

FUTURE MEETINGS, SEMINARS, COURSES

Allergy Program at Washington University

The Washington University School of Medicine, St. Louis, will conduct a postgraduate program on "Clinical Allergy for Practicing Physicians" on Sept. 26 and 27. For more info write Nancy Grimshaw, 660 S. Euclid Ave., St. Louis 63110.

American Society of Law & Medicine Sets Medical Malpractice Seminar

The National Medical Malpractice Seminar is scheduled for Pittsburgh on Oct. 24 and 25, under the sponsorship of the American Society of Law & Medicine. The registration fee is \$100. For full particulars write Dr. Cyril H. Wecht, Pittsburgh Institute for Legal Medicine, 1417 Frick Bldg., Pittsburgh 15219.

"ENT and the Practicing Physician"

A postgraduate course discussing new developments plus topics of current interest in Otolaryngology has been announced for Oct. 29 at Cleveland. It is being co-sponsored by the Division of Otolaryngology and Office of Continuing Medical Education, School of Medicine, Case Western Reserve University, and its associated hospitals. Write: School of Medicine, Case Western Reserve University, 2119 Abington Road, Cleveland, Ohio 44106.

Symposium on Cancer Chemotherapy

A one-day Symposium on Cancer Chemotherapy will be held Nov. 5, 1975, at the Conrad Hilton Hotel in Chicago. The Symposium is sponsored by the University of Chicago Cancer Research Center.

The following topics will be discussed: Combined Modality Therapy, Pharmacologic Considerations of Chemotherapeutic Agents, Adriamycin, Bleomycin, DTIC, Breast Cancer, Lymphoma, Acute Leukemia and Sarcomas and Carcinomas other than Breast Cancer. Registration forms may be obtained by writing to: John E. Ultmann, M.D., Director, University of Chicago Cancer Research Center, Box 444, 950 East 59th St., Chicago 60637.

Care of the Critically Ill Child Subject of Conference at Riley

A conference on the "Care of the Critically Ill Child," sponsored by the Indiana University School of Medicine and the James Whitcomb Riley Hospital for Children, will be held at Stouffer's Indianapolis Inn on November 5-6, 1975.

The registration fee is \$50.00. For more information, contact: Jay L. Grosfeld, M.D., or Morris Green, M.D., Riley Hospital for Children, 1100 West Michigan St., Indianapolis 46202.

Schedules Symposium on Lymphomas

I. U. School of Medicine will conduct a "Symposium on Lymphomas" on Nov. 5 for family practitioners, internists, hematologists and radiation therapists. The latest radiation and chemotherapy approaches will be discussed.

Northwestern University Schedules First Neoplasm Management Seminar

The Northwestern University Cancer Center will conduct its first Annual Postgraduate Seminar in "The Management of Common Neoplasms—Breast, Lung and Gastrointestinal" October 9 to 11 at the Rehabilitation Institute Auditorium, 345 E. Superior St., Chicago. Full registration fee is \$150. Cost to residents is \$75 when letter from Chief of Service accompanies the fee. Write Nathaniel I. Berlin, M.D., Ward Memorial Bldg., 303 E. Chicago Ave., Chicago 60611, or call Dr. John S. Schweppe, Coordinator, 312-642-9294.

Washington University Offers Course on Concepts and Prospects in Oncology

"Oncology—Current Concepts and Future Prospects" is the title of a continuing education program to be presented by the Washington University School of Medicine, St. Louis, October 23 to 25. The course is designed to provide the practicing physician with a review of the current management of the common malignancies, diagnosis and treatment. For details write Nancy Grimshaw, 660 S. Euclid Ave., St. Louis 63110, or call 314-367-9673.

INDIANA MEDICAL BUREAU

1010 East 86th St.—72 Winterton

Indianapolis 46240

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**A Licensed Employment Agency
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LINGERING DEATH

During a hectic New Year's Eve party, Pete fired a bullet into Eddie's back. For 24 months, Eddie lingered in the hospital. Finally he succumbed.

Could Pete be found guilty of murder?

A court said no, even though he could be punished for a lesser offense. The court invoked the "year-and-a-day" rule of the common law, which says there is no homicide un-

less death follows the injury within that period of time.

First laid down centuries ago, this rule continues in effect in most states. The idea is that after more than a year has gone by, it is just too difficult to tell whether the original injury or some later complication was the true cause of death.

Recently, however, a few states have done away with this specific time limit.

In a Pennsylvania case, 13 months had elapsed between a gunshot wound inflicted by the defendant and the demise of his victim. Yet the court upheld the verdict of murder in spite of the year-and-a-day rule.

"The reason for the rule," explained the court, "lay in the primitive state of medical knowledge at the time. A modern rule should be

based on current knowledge."

In some cases, of course, it is clear that an original injury was not the cause of death.

For example:

A man stabbed a bartender in the shoulder, inflicting a flesh wound that—under ordinary circumstances—would not have been fatal. But the doctor who treated the victim was so negligent that death did indeed ensue.

Could the original stabber be found guilty of homicide? Plainly not, ruled a court. The court said he simply had not taken the victim's life.

A public service feature of the American Bar Association and the Indiana State Bar Association. Written by Will Bernard.

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When **impotence** due to

androgenic deficiency

is driving them apart

Android®-5 MUQETS
BUCCAL Tabs
Android®-10 ORAL Tabs
Android®-25 ORAL Tabs

Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

**BROWN THE BROWN
PHARMACEUTICAL CO., INC.**

2500 West Sixth Street, Los Angeles, California 90057



Association News

EXECUTIVE COMMITTEE

June 7, 1975

The Executive Committee of the Indiana State Medical Association convened in the headquarters office at 6:00 p.m., on Sat. June 7, 1975. Dr. Donald M. Kerr, chairman, presided. Roll call showed the following present: Gilbert M. Wilhelmus, president; Richard G. Ingram, chairman of the Board; Joe Dukes, immediate past president; Hugh K. Thatcher, Jr., treasurer; Arvine G. Popplewell, assistant treasurer; Frank B. Ramsey, editor, *THE JOURNAL*; James A. Waggener, executive secretary, and Kenneth W. Bush, administrative assistant.

Dr. Peter R. Petrich, Attica, and Dr. Robert M. Reid, Indianapolis, were guests.

MINUTES OF THE MEETING HELD APRIL 30, 1975, were approved upon motion of Dr. Thatcher and a second by Dr. Ingram.

THE MEMBERSHIP REPORT was reviewed and special note was taken of the decrease in full dues-paying members of the Indiana State Medical Association as of May 31 and the increase in the number of ISMA members who have not paid AMA dues. It was hoped that by the end of the year these figures would look better.

Dr. Petrich was then called upon and went into detail concerning the use of Rocom in a pilot program at Winona Hospital as a test program for implementation of I-MEDIC. He pointed out to the Committee that there was some difficulty in getting the staff and the Board of Directors at Winona to accept this program. Dr. Petrich pointed out that in the beginning it was planned that these programs would be run through a contractual agreement between Rocom and ISMA and that he was asking for permission of the Committee to advise Rocom to deal directly with Winona Hospital rather than through ISMA.

Dr. Reid, representing Medi-Tech, was then called upon and he explained how Medi-Tech could handle this problem and again stressed the fact that only Medi-Tech could provide the confidentiality of the information collected through this system.

Following a lengthy discussion, it was agreed that this matter should be referred to the Board of Trustees, with the recommendation that Rocom deal directly with Winona Hospital and the advantages and disadvantages of the Rocom system and Medi-Tech system be further studied.

HEADQUARTERS OFFICE

The secretary presented a letter and materials from the Howard E. Nyhart Company, the administrator of the employee retirement plan, calling attention to the fact that our retirement program must be changed by Jan. 1, 1976, to conform to the new federal regulations. Upon motion of President Wilhelmus and taken by consent, this item was referred to the Board Committee on Economics and Fiscal Matters.

The secretary reported that the variance on the property at 3942 N. Pennsylvania St. would become effective as of midnight June 8, which would constitute 30 days for objections to be filed. As of this report no objection has been filed.

ORGANIZATION MATTERS

A letter from legal counsel suggesting that the Association might settle the Myrtle Lynn will matter by accepting 50% of the estate. This was approved on motion of Dr. Thatcher and a second by President Wilhelmus.

LETTER FROM WILLIAM PAYNTER, M.D., COMMISSIONER OF THE STATE BOARD OF HEALTH, inquiring whether the Association would sponsor a program on ASTHO, AMA, for the training of medical directors of nursing homes, was deferred until the August meeting.

MINUTES OF THE COMMISSION ON INTERPROFESSIONAL RELATIONS were reviewed and no action taken.

LETTER FROM THE AMERICAN MEDICAL ASSOCIATION regarding the Association financing a representative of the housestaff to the Atlantic City meeting was reviewed and, by consent, it was regretfully turned down because of budgetary problems.

REQUEST OF DR. JOHN W. BEELER for the Association to undertake an informational program recommending that those patients who have had thyroid and thymus gland treatment by x-ray be advised to contact their physician for examination for possible cancerous effects from this treatment. Upon motion of President Wilhelmus and taken by consent, Dr. Beeler is to be requested to prepare an article for insertion in *THE JOURNAL* and he is to be invited to attend the next meeting of the Board to explain this matter and that no publicity should be given prior to July 1, 1975.

The Executive Secretary brought up the matter of the DEPARTMENT OF FINANCIAL INSTITUTIONS to place physicians under the Consumer Credit Code and reviewed the action taken by this organization in 1971-72, which is at variance with the present action of the Department. He requested permission to again refer this matter to the Association's legal counsel to determine if in their opinion physicians are, in fact, required to register under this act. Request

was granted upon motion of Dr. Ingram and a second by Dr. Dukes.

LETTER FROM THE INDIANA NURSING HOME ASSOCIATION was turned over to President Wilhelmus for reply.

A dues refund for a deceased member was approved by consent.

A LETTER FROM WAYNE STANTON, DIRECTOR OF THE STATE DEPARTMENT OF PUBLIC WELFARE addressed to President Wilhelmus, requesting the appointment of a fee review committee by the State Medical Association, was deferred upon motion of President Wilhelmus and a second by Dr. Thatcher until more information is available.

A LETTER FROM INDIANA UNIVERSITY SCHOOL OF MEDICINE was, by consent, turned over to President Wilhelmus.

REQUEST OF INDIANA PHYSICIAN SUPPORT AGENCY for a letter of endorsement was denied by consent.

A LETTER FROM A PHYSICIAN ADDRESSED TO RETAIL CREDIT COMPANY was reviewed and taken as a matter of information.

THE SECRETARY PRESENTED A LIST OF VACANCIES ON VARIOUS STATE BOARDS which would occur this year. By consent, it was agreed that this list should be duplicated and distributed to the members of the Board.

THE SECRETARY ANNOUNCED THE CHECK OF \$1,000 issued in 1974 to support the Indiana Joint Practice Commission had never been cashed and he had ordered payment stopped on the check.

A LETTER FROM THE INDIANA HOSPITAL ASSOCIATION requesting a meeting of the executive committees of their organization and the Indiana State Medical Association was reviewed and it was agreed to attempt to hold a meeting on June 29 at 12:30 p.m., with a cold buffet to be served.

CONVENTION MATTERS

A LIST OF THOSE WHO WILL JOIN THE 50-YEAR CLUB in 1975 was reviewed for the purpose of selecting an individual to give the response. By consent, Dr. Alexander W. Cavins is to be asked to make this response.

The list of invited guests for the 1975 meeting will be the same as the 1974 meeting, guests to be seated at the speaker's table, and arrangements to be left to President Wilhelmus.

BLUE CROSS-BLUE SHIELD MATTERS

LETTER FROM E. R. GABOVITCH, M.D. Upon motion of Dr. Dukes and a second by President Wilhelmus this letter is to be referred to the Blue Shield Director of his district and to the Mari-

on County Medical Society.

LETTER FROM KATHRYN K. RICE, M.D. Upon motion of Dr. Dukes and a second by Dr. Thatcher this letter is to be sent to the Blue Shield Director of the district and the county medical society.

LETTER FROM BLUE CROSS-BLUE SHIELD addressed to the Clinton County Hospital is to be referred to the Blue Shield Director of that district and the Trustee.

AMA CANDIDATES. The secretary announced he had received a notice from Wisconsin that Frederick H. Hofmeister, M.D., was a candidate for the Council on Medical Education and a letter from New Jersey announcing the candidacy of Louis E. Albright, M.D., for the same council.

It was announced that the Board of Trustees and the Council on Medical Educa-

tion had endorsed Patrick J. V. Corcoran, M.D., for a position on the Council on Medical Education and upon motion of Dr. Thatcher and a second by Dr. Dukes, this is to be referred to the Board of Trustees with the recommendation that the Board officially endorse Dr. Corcoran's candidacy.

President Wilhelmus then brought up the matter of Mr. Waggener serving as secretary of the Forum For Medical Affairs and this is to be referred to the Board of Trustees.

THE JOURNAL

The secretary reported that the editor of THE JOURNAL has discussed with him the advisability of increasing the rates of advertising in THE JOURNAL and the editor commented upon this matter. Upon motion of Dr. Dukes and taken by consent, Dr. Ramsey is to continue to

investigate this matter.

Request for advertising space in THE JOURNAL by Midwest Medical, Inc., was approved by consent.

The question arose concerning advertising in THE JOURNAL and it was suggested that the Association develop a policy with respect to advertising by the Women's Clinic and laboratory advertising.

NOTICE OF AMA INVITATIONAL CONFERENCE ON PROFESSIONAL LIABILITY to be held in Chicago, July 9. Upon motion of Dr. Dukes and taken by consent, President Wilhelmus or Dr. Santare to attend this meeting.

There being no further business, the committee adjourned to meet again on August 8, 1975, at the Inn of the Fourwinds, providing the Board sets its meeting for August 8, 9 and 10.

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—July 1975

Disease	July 1975	June 1975	May 1975	July 1974	July 1973
Animal Bites	1151	1375	1556	1108	1413
Chickenpox	57	240	634	73	122
Conjunctivitis	150	186	272	187	304
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	35	90	104	79	34
Gonorrhea	1033	1082	1863	956	686
Impetigo	143	98	166	188	259
Infectious Hepatitis	42	45	58	58	45
Infectious Mononucleosis	25	56	91	36	35
Influenza	1133	1222	2298	2345	1063
Measles					
Rubeola	14	13	80	10	59
Rubella	23	349	268	26	21
Meningococcic Meningitis	1	0	2	1	0
Meningitis, Other	6	5	6	2	0
Mumps	59	72	462	46	83
Pertussis (Whooping Cough)	9	12	6	4	2
Pneumonia	178	302	424	270	297
Poliomyelitis	0	0	0	0	0
Streptococcal Infection	584	888	1400	897	738
Syphilis					
Primary and Secondary	13	11	12	10	12
All Other Syphilis	125	119	115	76	65
Tinea Capitis	5	8	21	12	8
Tuberculosis (Active)	39	54	54	28	53

COMMERCIAL ANNOUNCEMENTS

FOR SALE — 1973 Mercedes Benz 450SL, blue, 26,500 actual miles; p.s., p.b., cruise control, tape deck, two tops, excellent condition, \$12,500. 317-251-4958.

FOR SALE — Office furniture: 2 executive desks, 2 secretary desks, chairs, instrument cabinets, electric Underwood office typewriter, two examining tables, excellent condition. 317-251-4958.

"EAR, NOSE AND THROAT AND THE PRACTICING PHYSICIAN"
—A Postgraduate Course discussing new developments plus topics of current interest in Otolaryngology. Co-sponsored by the Division of Otolaryngology and Office of Continuing Medical Education, School of Medicine, Case Western Reserve University and its Associated Hospitals.

Date: October 29, 1975

Location: School of Medicine, Case Western Reserve University, 1219 Abington Road, Cleveland, Ohio 44106.

CHALLENGING AND INTERESTING WORK at Fort Wayne State Hospital and Training Center. An opening for a physician licensed in the State of Indiana at this 1200-bed facility for the retarded. Forty-hour week, excellent fringe benefits including health and life insurance. Contact the Medical Director or Mr. George Smith, Personnel Director, 801 E. State Blvd., Fort Wayne, IN 46805.

FOR RENT — Luxuriously furnished two-bedroom beach condominium on Marco Island, southwestern Florida, overlooking Gulf and island. Weekly or monthly. Swimming, fishing, boating, golf and tennis. Call 317-291-7655.

ONE OR TWO PHYSICIANS for Family Medicine being sought. Town of 9,000 with a service area of 24,000. Located in West Central Indiana. 108 bed hospital, JCAH Accredited. For further information contact S. R. Farid, M.D., Chief of Staff, Clay County Hospital, 1206 East National Avenue, Brazil, Indiana, 47834.

PURDUE DEFIBRILLATION CONFERENCE

The Biomedical Engineering Center of Purdue University will hold a conference in Lafayette, Indiana, from October 1 to 3, 1975, covering the practical and clinical aspects of cardiac defibrillation. The speakers have been selected based upon their positions as leaders in their respective fields. The topics to be discussed include clinical, basic science, and engineering aspects of electrical defibrillation as it pertains to the needs of physicians, nurses, emergency medical personnel, hospital engineers, equipment manufacturers, and research scientists. The state-of-the art of defibrillation techniques will be presented and examined critically and a major goal of this three-day conference will be to integrate all available technology for optimization of ventricular defibrillation. The registration fee of \$95 includes proceedings and two luncheons.

For further information, please Write: Division of Conferences and Continuation Services, Stewart Center, Purdue University, West Lafayette, Indiana 47907; or Phone: (Area Code 317) 749-2533

WANTED—Internist to associate with board certified general internist with or without subspecialty. Must be willing to practice general internal medicine. New office facilities; lab, x-ray treadmill, etc. Graduate of American medical school preferred. Write to L. Lenyo, M.D. 2100 North Center Street, Terre Haute, Indiana 47804.

DOCTORS—THE NEXT MOVE IS YOURS . . . Midwest Medical, Inc. will provide you with more information about each opportunity than you have ever imagined possible. For the first time you can visually preview the Community and Medical Facilities of over 80 opportunities in the Upper Midwest, at ONE location. Saves you time, expense, and frustration. For a thorough appraisal of all factors involved, please accept our invitation to call. For discreet and confidential assistance contact M. A. Cornwall, M.D., MMI's Medical Director, or write: Midwest Medical, Inc., Lakeland, Minnesota 55043, 612/436-5161. Locum Tenens opportunities always available.

FOR SALE OR LEASE: Modern medical building in Mooresville, fully equipped, ample parking. Formerly owned by Robert Van Bokkelen, M.D. Write or call Gordon Smith, attorney for executor, 2470 Indiana National Bank, Indianapolis 46204; 317-632-4402.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be consid-

ered for display type advertising.

Charges for commercial announcements are:

15¢ for each word

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Send cash with order. Average count: seven words to the line.

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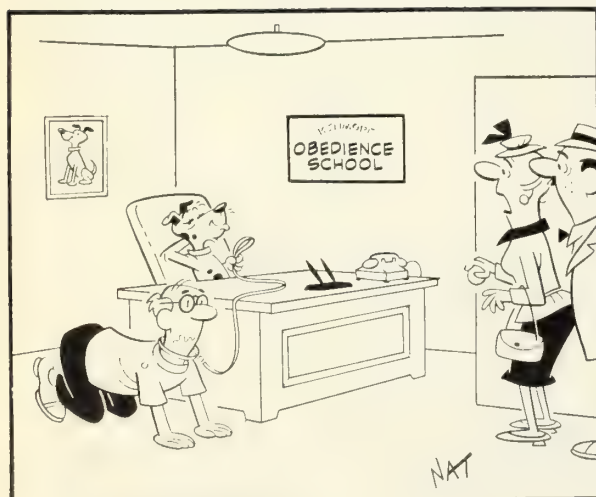
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Family Security Foods	765
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Inn of The Fourwinds	774
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"I WAS AFRAID SOMETHING LIKE THIS WOULD HAPPEN!"

126th

Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

October 20, 21 and 22, 1975

All Events on Eastern Standard Time

French Lick Sheraton Hotel

French Lick, Indiana

*Complete Program and
Annual Reports on
Following Pages*

CONVENTION SECTION

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Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the French Lick-Sheraton Hotel, French Lick, Ind., October 20, 21 and 22, 1975.

The House of Delegates will be constituted as follows: Marion County, twenty-four delegates; Lake County, ten delegates; Allen and Vanderburgh counties, each six delegates; St. Joseph County, five delegates; Delaware-Blackford, Owen-Monroe, Tippecanoe and Wayne-Union county societies, each three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Grant, Harrison-Crawford, Jefferson-Switzerland, LaPorte, Madison, Parke-Vermillion, Porter and Vigo county societies, each two delegates; the other 57 county societies, each one delegate; fourteen trustees and the ex-presidents, namely, Herman M. Baker, M. C. Topping, Kenneth L. Olson, Earl W. Mericle, Guy A. Owsley, Maurice E. Glock, Donald E. Wood, Joseph M. Black, Eugene S. Rifner, Patrick J. V. Corcoran, Lowell H. Steen, Malcolm O. Scamahorn, Peter R. Petrich, James H. Gosman and Joe Dukes. The American Medical Student Association, one delegate. The delegate or their designated alternate delegate elected by their respective section shall also be a member but without power to vote. The following shall be ex officio members; the president, president-elect, the executive secretary, the treasurer, the assistant treasurer, the speaker, the vice-speaker and the delegates to the American Medical Association, all without power to vote, except in the case of a tie vote, when the president or person presiding shall cast the deciding vote.

All delegates must present their credentials card certified by their county medical society before being seated as a delegate. No delegate will be seated without proper certification.

The House of Delegates will convene promptly at 9:00 a.m., EST, Monday, October 20, 1975, in the Convention Hall of the French Lick-Sheraton Hotel, French Lick. The final meeting of the House of Delegates will convene at 9:00 a.m., Wednesday, October 22, in the Convention Hall.

The order of business will be as follows:

1. Call to order by the president.
2. Invocation.
3. Roll call and seating of qualified delegates.
4. Announcements from the chair.
5. Tribute to members of the House or those who served the association in an official capacity and who have died since the 1974 session.
6. Reading of minutes of previous meetings.
7. Introduction of guests.
8. President's address.
9. Appointment of Reference Committees and assignment of meeting rooms.
10. Unfinished business.
11. Address of president-elect.
12. Report of president of the Indiana State Medical Auxiliary.
13. Report of the Indiana Chapter, American Medical Student Association.
14. Report of president of Blue Shield.
15. Report of executive secretary.
16. Report of treasurer.
17. Report of chairman of the Board.

18. Report of trustees.
19. Report of *The Journal* editor.
20. Report of AMA delegates.
21. Report of Indiana Medical Licensing Board.
22. Reports of committees and commissions.

COMMITTEES

- (1) Executive
- (2) Grievance
- (3) Future Planning
- (4) Student Loan
- (5) Medical-Legal Review
- (6) Sports and Medicine

COMMISSIONS

- (1) Aging
 - (2) Constitution and Bylaws
 - (3) Convention Arrangements
 - (4) Emergency Medical Services
 - (5) Governmental Medical Services
 - (6) Interprofessional Relations
 - (7) Legislation
 - (8) Medical Economics and Insurance
 - (9) Medical Education and Licensure
 - (10) Public Health
 - (11) Public Information
 - (12) Special Activities
 - (13) Voluntary Health Agencies
23. New Business:
- (1) Matters referred by the Board of Trustees
 - (2) Matters referred by the Executive Committee
 - (3) Resolutions
 - (4) Selection of city for 1980 meeting
1976—Indianapolis—October 9-14
1977—Indianapolis—October 10-14
1978—French Lick—October 14-19
1979—Indianapolis—dates to be set by Board of Trustees

The election of officers will be the first order of business at the final meeting of the House of Delegates. In addition to the regular officers, the terms of the following AMA delegates and alternates expire December 31, 1975, and their successors must be elected at the session: Delegates to the American Medical Association to succeed Patrick J. V. Corcoran, Evansville, and Lowell H. Steen, Hammond; alternate delegates to succeed Thomas C. Tyrrell, Hammond, and Peter R. Petrich, Attica.

Delegates from the Second, Fifth, Seventh, Eighth and Eleventh Districts are reminded that the terms of their trustees will expire October 22, 1975, and new trustees should be elected to succeed the following:

- Second—Paul W. Holtzman, Bloomington
Fifth—Cleon M. Schauwecker, Greencastle
Seventh—Joseph F. Ferrara, Franklin
Eighth—Richard G. Ingram, Montpelier
Eleventh—James A. Harshman, Kokomo

Some of these elections may already have been held, but they should be reported to the House of Delegates at this session for confirmation.

JAMES A. WAGGENER, Executive Secretary

HOUSE OF DELEGATES

Indiana State Medical Association French Lick—October 20, 21 and 22, 1975

County and Delegates	Alternates	County and Delegates	Alternates
ADAMS (1) Norman E. Beaver Berne	Hyung S. Lee Decatur	DE KALB (1) William Hathaway Auburn	John Harvey Auburn
ALLEN (6) William R. Cast Fort Wayne Thomas A. Felger Fort Wayne DeWayne L. Hull Fort Wayne Fred W. Dahling New Haven Marvin E. Priddy Fort Wayne Karl R. Schlademan Fort Wayne Charles H. Aust Fort Wayne	Jerry H. Connelly Fort Wayne James J. Harris Fort Wayne Charles E. Schoenhals Fort Wayne David P. Schlueter Fort Wayne Philip C. Schubert Fort Wayne John R. Thomas Fort Wayne Harry D. Tunnell Fort Wayne	DELAWARE-BLACKFORD (3) Warren L. Bergwall Muncie Paul E. Burns Montpelier Ross L. Egger Daleville	Larry Cole Yorktown Richard Reedy Yorktown Serverino T. Sulit Hartford City
BARTHOLOMEW-BROWN (2) C. David Ryan Columbus Robert M. Seibel Nashville	Lindley L. Gammell Columbus	DUBOIS (1) Daniel C. Drew Jasper	Harry L. Craig Huntingburg
BENTON (1) Manuel Scheurich Oxford		ELKHART (2) William Kraybill Goshen James Miller Wakarusa	Donald Minter Goshen John Collins Elkhart
BOONE (1) Don W. Boyer Lebanon		FAYETTE-FRANKLIN (2) William F. Kerrigan Connersville Perry F. Seal Brookville	John M. Lockhart Connersville Noli C. Guinigundo Brookville
CARROLL (1) T. Neal Petry Delphi		FLOYD (1) Everett E. Bickers Floyd Knobs	William V. Johnson New Albany
CASS (1) Richard L. Glendening Logansport		FOUNTAIN-WARREN (2) Max N. Hoffman Covington A. S. Salvo Williamsport	Lowell R. Stephens Covington Carl A. Nelson West Lebanon
CLARK (1) William R. Greene Henryville		FULTON (1) James P. Schalliol Rochester	Charles L. Herrick Akron
CLAY (1) Robert Oehler Brazil		GIBSON (1) Don Pruitt Evansville	William Dye Oakland City
CLINTON (1) Lee F. Dupler Frankfort		GRANT (2) Robert Brown Marion Herbert Khalouf Marion	Shirley Khalouf Marion Charles R. Kershner Marion
DAVIESS-MARTIN (2) Marshall H. Seat Washington Robert E. Chattin Loogootee		GREENE (1) William R. Powers Lyons	Carl M. Porter Jasonville
DEARBORN-OHIO (2) Henry W. Conrad Lawrenceburg Gordon Fessler Rising Sun		HAMILTON (1) A. Adrian Lanning Noblesville	
DECATUR (1) Robert P. Acher Greensburg		HANCOCK (1) James T. Anderson Greenfield	James L. Garrison Cumberland
	Ivan T. Lindgren Aurora	HARRISON-CRAWFORD (2) David J. Dukes Corydon	Richard Allen Jordan Corydon
	Dale D. Dickson Greensburg		

County and Delegates	Alternates	County and Delegates	Alternates
HENDRICKS (1) Robert W. Kirtley Danville	Eric D. Clark Plainfield	LA PORTE (2) John Luce Michigan City Barbara Backer LaPorte	Peter J. Pilecki Michigan City William G. Moore LaPorte
HENRY (1) Kenneth G. Hill New Castle	Frank C. McDonald New Castle	LAWRENCE (1) James L. Mount Bedford	Florian S. Dino Bedford
HOWARD (1) Jack W. Higgins Kokomo	Richard P. Miethke Kokomo	MADISON (2) William J. Gray Anderson Ralph E. Reynolds Middletown	Gerald P. Irwin Alexandria Frank Campbell Anderson
HUNTINGTON (1) Richard G. Blair Huntington	Paul E. Doermann Huntington	MARION (24) Hugh K. Thatcher, Jr. Indianapolis Malcolm L. Wrege Indianapolis Ted H. Gabrielson Greenfield Karl M. Koons, Jr. Indianapolis Loren M. Martin Indianapolis Charles E. Test Indianapolis Hugh L. Williams Indianapolis John W. Beeler Indianapolis B. T. Maxam Indianapolis I. E. Michael Indianapolis Morris E. Thomas Indianapolis John G. Pantzer Indianapolis D. Edmund Storey Indianapolis Albert M. Donato Indianapolis A. Alan Fischer Indianapolis E. Henry Lamkin, Jr. Indianapolis Thomas J. Lord Indianapolis George T. Lukemeyer Indianapolis George F. Parker Indianapolis Arvine G. Popplewell Indianapolis Charles R. Thomas Indianapolis Fred L. Toumey Indianapolis	Berj Antreasian Indianapolis James F. Balch, Jr. Indianapolis Richard A. Brickley Indianapolis Fred R. Brooks, Jr. Indianapolis Michael W. Manzie Indianapolis John N. Pittman Indianapolis Rolla D. Burghard Indianapolis Frank W. Fortuna Indianapolis John D. Graham Indianapolis Kenneth L. Gray Indianapolis Gerald J. Kurlander Indianapolis John D. Moriarty Indianapolis Stafford W. Pile Indianapolis Douglas H. White, Jr. Indianapolis Albert L. Blake Indianapolis Helen G. Czenkusch Indianapolis William E. Graham Indianapolis Russell L. Judd Indianapolis Paul F. Muller Indianapolis Dennis Nicholas Indianapolis George H. Rawls Indianapolis Loyd K. Stump Indianapolis
JACKSON (1) John C. Linson Seymour	William F. Blaisdell Seymour		
JASPER (1) Kenneth J. Ahler Rensselaer	P. A. Williams Rensselaer		
JAY (1) James S. Fitzpatrick Portland	Eugene M. Gillum Portland		
JEFFERSON-SWITZERLAND (2) Ott B. McAtee Madison Diego C. Valenzuela Vevay	W. R. Rucker Madison		
JENNINGS (1) James Calli, Sr. North Vernon	F. Richard Walton North Vernon		
JOHNSON (1) Joseph W. Young Greenwood			
KNOX (1) Norbert M. Welch Vincennes	Jack L. Shanklin Vincennes		
KOSCIUSCO (1) Wymond B. Wilson Mentone	David W. Hines Warsaw		
LA GRANGE (1) Michael O. Mellinger LaGrange			
LAKE (10) Leonard W. Neal Munster Peter E. Gutierrez Crown Point Walfred A. Nelson Gary William G. Grosso East Chicago David E. Ross Gary Charles D. Egnatz Schererville Thomas C. Tyrrell Hammond Nicholas L. Polite Hammond Theodore R. Espy Gary Thomas A. Gehring Merrillville	Robert J. Bills Gary Reginald R. Barton Gary John J. Reed Hobart Donald H. Rudser Whiting Lee H. Trachtenberg Munster Walter A. Repay Munster S. A. Gonzalez Highland Aloys M. Rieser Crown Point Robert A. Wolf Gary		
		MARSHALL (1) John K. Guild Plymouth	
		MIAMI (1) Lloyd Hill Peru	
		MONTGOMERY (1) Thomas C. Haller Crawfordsville	Richard R. Eggers Crawfordsville

County and Delegates	Alternates	County and Delegates	Alternates
MORGAN (1) David A. Eisenberg Martinsville	Lowell R. Steele Mooreville	SCOTT (1) Marvin L. McClain Scottsburg	Jesus C. Bacala Scottsburg
NEWTON (1) M. S. Guzman Morocco		SHELBY (1) Wilson L. Dalton Shelbyville	
NOBLE (1) Robert C. Stone Ligonier	Carl F. Stallman Kendallville	SPENCER (1) John H. Barrow Dale	
ORANGE (1) Phillip T. Hodgins Orleans	Charles X. McCalla Paoli	STARKE (1) W. Allen Palmer Knox	Herbert C. Ufkes North Judson
OWEN-MONROE (3) Charles W. McClary Bloomington Roger F. Robison Bloomington Robert E. Rose Spencer	Jean A. Creek Bloomington Walter L. Owens Bloomington Rodger L. Buck Spencer	STEUBEN (1) R. Wyatt Weaver Angola	Dean B. Jackson Angola
PARKE-VERMILLION (2) Gheorghe Alexandrescu Clinton		SULLIVAN (1) Betty J. Dukes Sullivan	Glen McClure Sullivan
PERRY (1) Robert A. Ward Tell City	Gene E. Ress Tell City	TIPPECANOE (3) George M. Underwood Lafayette Grayson B. Davis Lafayette	Robert E. Hannemann Lafayette John A. Knote Lafayette Ben Z. Klatch Lafayette
PIKE (1) Donald L. Hall Petersburg		TIPTON (1) Meredith B. Gossard Tipton	
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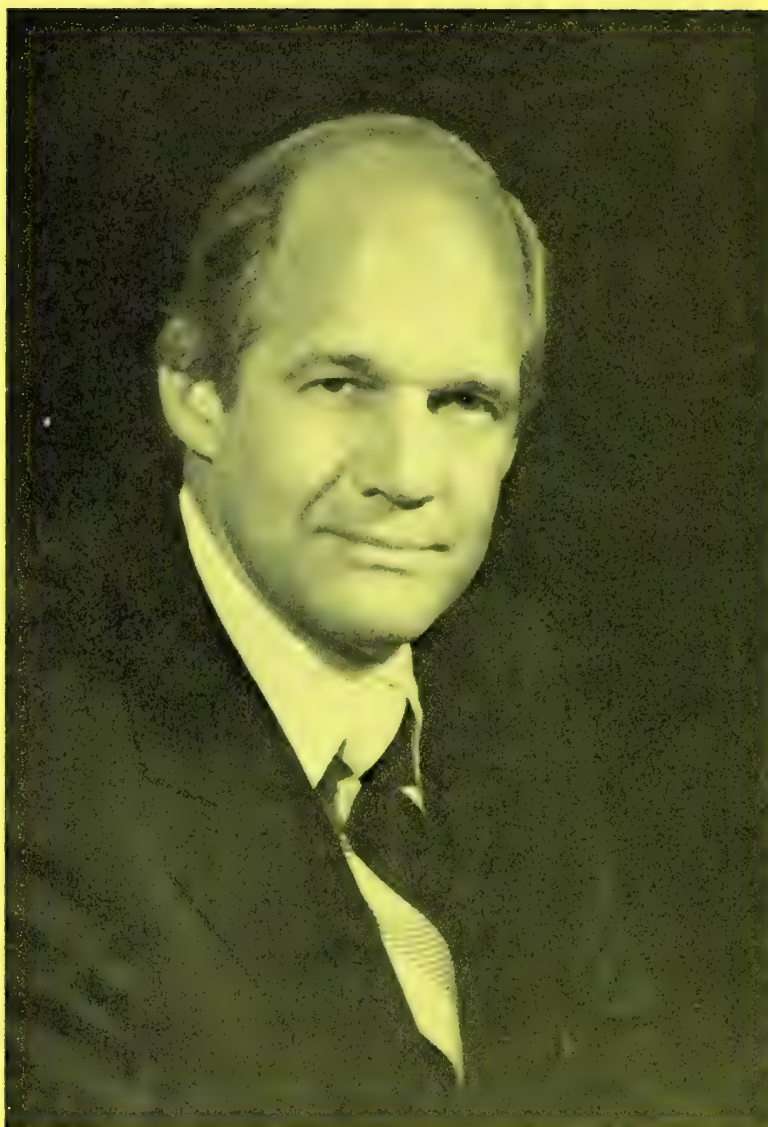
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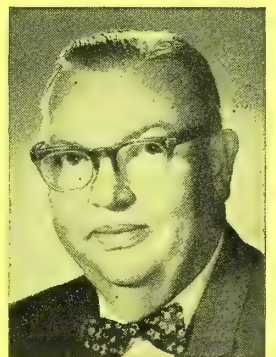
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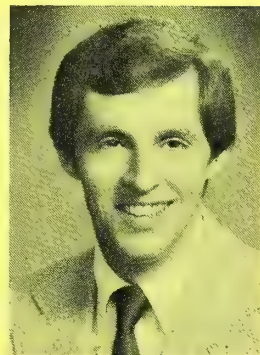
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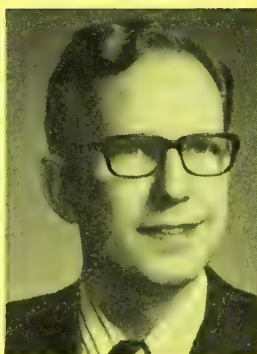


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JOHN O. BUTLER, M.D.
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JOSEPH F. FERRARA, M.D.
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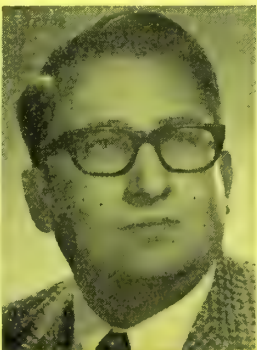
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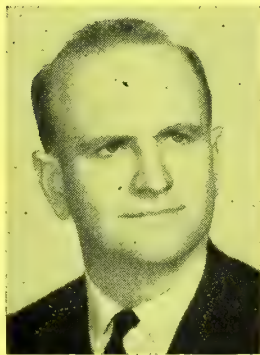
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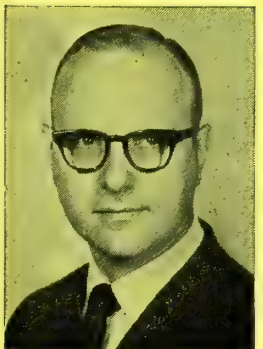
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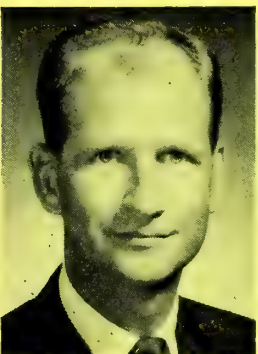


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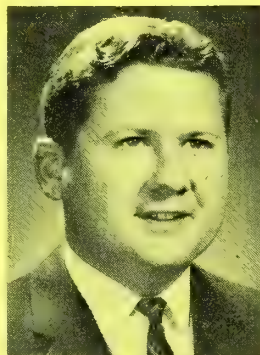


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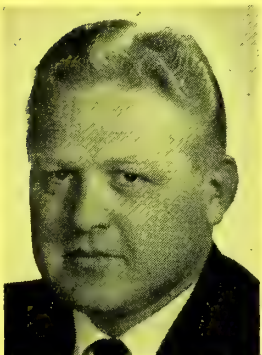


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Indianapolis

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ROBERT M. SEIBEL, M.D.
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DAVID C. GASTINEAU,
M.D.
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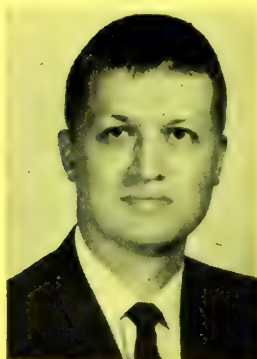
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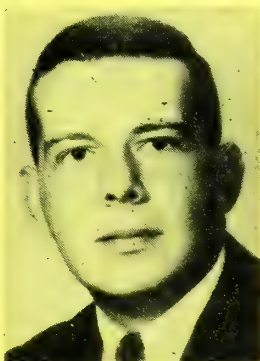
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College Health Physicians



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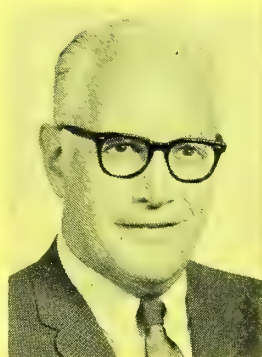
FLOYD THURSTON, M.D.
Bloomington

Allergy

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IRVIN CAPLIN, M.D.
Indianapolis



WILLIAM MOUNT, M.D.
Lafayette

JULIAN KAUFMAN, M.D.
Fort Wayne

Urology



FRANK B. ADNEY, M.D.
Richmond



RUSSELL L. JUDD, M.D.
Indianapolis

Schedule of Events

126th Annual Convention

French Lick-Sheraton Hotel

French Lick, Indiana

(All Events will be on Eastern Standard Time)

(The scientific program for the 126th Annual Convention of the Indiana State Medical Association is acceptable for 11 prescribed and 6 elective hours by the American Academy of Family Physicians. The prescribed hours are for attendance at the Family Physicians Section meeting.)

(Scientific programs presented at the 1975 ISMA Convention are accredited on an hour-for-hour basis for inclusion in Category 1 of the application for the AMA Physician's Recognition Award. Hours allowable in any given program are shown beside the program listing.)

Sunday, October 19, 1975

- 10:00 a.m. Executive Committee Meeting
Hoosier Jr. Dining Room
- 10:00 a.m. GOLF AND TENNIS TOURNAMENTS
(Hugh A. Stallings, M.D., Evansville,
Golf Chairman)
(Roger Barnard, M.D., Evansville,
Tennis Chairman)
- 2:00 p.m. Board of Trustees Meeting
Roost Room
- 8:00 p.m. Board of Trustees Annual Dinner
West Dining Room

Section on Ophthalmology and Otolaryngology and Indiana Academy of Ophthalmology and Otolaryngology

(Possible Hours of Accreditation—2.0)

Room 602-04

- 7:30 p.m. Panel on Socioeconomic Problems
PREPAID EYE CARE, COLORADO
REPORT, Mr. Dean Russman, Denver
GLAUCOMA, WHEN IS IT LEGAL?
Richard Eberhardt, J.D., Denver

PHYSICIAN LIABILITY INSUR-
ANCE, INDIANA 1975, William R.
Cast, M.D., Fort Wayne
OSHA 1975 — THE EFFECTS ON
THE PRACTICE OF OPHTHAL-
MOLOGY AND OTOLARYNGOL-
OGY, Leo G. Watson, M.D., Kokomo,
and J. William Wright, Jr., M.D., In-
dianapolis
Election of 1976 Section Officers

Monday, October 20, 1975

- 8:00 a.m. Registration Begins, Convention Hall
Opening of Technical and Scientific Ex-
hibits
Art and Hobby Show
Card Room
- 9:00 a.m. House of Delegates Meeting
Convention Hall

"MEET THE PROFESSOR"

(The Department of Medicine of Indiana
University School of Medicine has ar-
ranged to conduct these conferences.)

*(Possible Hours of Accreditation—4.0 for entire
session)*

Parlors A and B

- 10:00 a.m. DIAGNOSIS AND TREATMENT OF
HYPERTENSION, C. E. Grim, M.D.,
Associate Professor of Medicine, Mem-
ber of Staff of Specialized Center for
Research in Hypertension
- 11:00 a.m. GALLSTONES IN THE BILIARY
TREE AND PANCREATITIS, Philip
Snodgrass, M.D., Professor of Medi-
cine, Chief of Medicine, Veterans Ad-
ministration Hospital
- 2:00 p.m. CONCEPTS FROM THE CORONARY
CARE UNIT, Joseph Noble, M.D.,
Associate Professor of Medicine
- 3:00 p.m. DIAGNOSIS AND TREATMENT OF
INFECTIOUS DISEASES, William
Hoppe, M.D., Assistant Professor of
Medicine

Monday, October 20, 1975

SPEAKERS

**Section on Directors of Medical Education and
Association of Indiana Directors of Medical Education**
(Possible Hours of Accreditation—2.5)
Room 107

- 10:30 a.m. to 12 noon **WORKSHOP AND PANEL DISCUSSION ON HOSPITAL MEDICAL STAFF CONTINUING MEDICAL EDUCATION**
Norman S. Stearns, M.D., Boston, Associate Dean, Tufts University School of Medicine, Moderator
Steven C. Beering, M.D., Dean, Indiana University School of Medicine
Oscar Hufnagle, Associate Director, Medical Education Administration, Methodist Hospital, Indianapolis
Lindley H. Wagner, M.D., Director, Medical Education, St. Elizabeth and Home Hospitals, Lafayette
Paul S. Rhoads, M.D., Director, Medical Education, Reid Memorial Hospital, Richmond
Barbara Backer, M.D., Director, Medical Education, LaPorte Hospital
- 12 noon **Luncheon—Room 107**
SUCCESS IN CONTINUING MEDICAL EDUCATION IN COMMUNITY HOSPITALS, Norman S. Stearns, M.D.
- 1:30 p.m. **Business Meeting — Election of 1976 Section Officers**
- 12 noon **PAST PRESIDENTS LUNCHEON**
Hoosier Jr. Dining Room
- 12 noon **Luncheon, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS**
Roost Room
FREEDOM OF PRIVATE PRACTICE, Jose L. Garcia Oller, M.D., New Orleans, president, American Council of Medical Staffs

JOSE L. GARCIA OLLER
New Orleans, La.

President, American Council of Medical Staffs; diplomate, American Board of Neurological Surgery; member Alpha Omega Alpha; chief of staff, Mercy Hospital, New Orleans; charter member, Research Engineering Society of America; M.D. degree from Jefferson Medical College, Philadelphia.



FREDERIC L. SCHOEN, M.D.
Fort Wayne

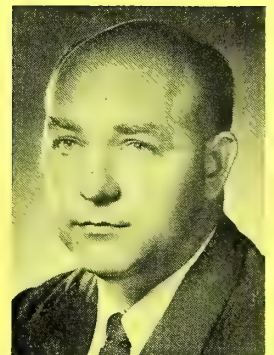
Assistant professor of medicine, Indiana University; medical director, Physician Assistant Program, I.U.S.M.; diplomate, American Board of Family Practice; in 1975 received the Lester Bibler Award as Family Physician of the Year; M.D. degree from Washington University, St. Louis.

Section on Family Physicians
(Possible Hours of Accreditation—4.0)
Terrace Room

- 12:15 p.m. **Luncheon—Terrace Room**
Business Meeting — Election of 1976 Officers
EXTENDING THE PHYSICIAN
(Symposium on Paramedical Personnel)
I THE PHYSICIAN'S ASSISTANT
- 1:00 p.m. Frederic L. Schoen, M.D., Fort Wayne
1:15 p.m. Dan W. Hibner, M.D., Richmond
1:30 p.m. Wilson L. Dalton, M.D., Shelbyville
1:45 p.m. Questions

WILSON L. DALTON, M.D.
Shelbyville

General practitioner; M.D. degree from Indiana University School of Medicine in 1950.



SPEAKERS



RAYMOND H. MURRAY, M.D.
Indianapolis

Professor of community health sciences and medicine, Indiana University; specialty in internal medicine and cardiology; M.D. degree from Harvard Medical School.

A. ALAN FISCHER, M.D.
Indianapolis

Professor and Chairman of the Department of Family Medicine, I.U. School of Medicine; former vice president of the American Academy of Family Practice; M.D. degree from I. U. School of Medicine in 1952.



FOREST D. DAUGHERTY, M.D.
Columbus

Specialty in family practice; graduate of Indiana University School of Medicine in 1957.

DAVIS W. ELLIS, M.D.
Rushville

Specialty in family practice; graduate of Indiana University School of Medicine.



PATRICK W. CONNERLY, M.D.
Rushville

Specialty in family practice; presently in his third year as a commissioned officer in the National Health Service Corps; M.D. degree from Indiana University School of Medicine.



PAUL A. WILLIAMS, M.D.
Rensselaer

Assistant professor, Indiana University School of Medicine; college physician and team physician, St. Joseph's College; specialty in Family Practice; M.D. degree from Tulane University School of Medicine.



JAMES A. KENNY, Ph.D.
Rensselaer

Psychologist at Jasper-Newton Mental Health Clinic and professor of psychology, St. Joseph's College, Rensselaer; M.S.W., Loyola, Chicago; Ph.D. in anthropology from Indiana University and Ph.D. in psychology from University of Mainz, Germany.

Monday, October 20, 1975

II THE FAMILY NURSE PRACTITIONER; PEDIATRIC NURSE ASSISTANT

- 2:00 p.m. Raymond H. Murray, M.D., Indianapolis
- 2:15 p.m. A. Alan Fischer, M.D., Indianapolis
- 2:30 p.m. Forest D. Daugherty, M.D., Columbus
- 2:45 p.m. Questions

III THE NATIONAL HEALTH SERVICE CORPS

- 3:00 p.m. Davis W. Ellis, Jr., M.D., Rushville
- 3:15 p.m. Patrick W. Connerly, M.D., Rushville
- 3:30 p.m. Eldon Kronewitter, Chicago, Region V, National Health Service Corps
- 3:45 p.m. Questions

IV OTHER PARAMEDICAL PROFESSIONAL PERSONNEL

- 4:00 p.m. Paul A. Williams, M.D., Rensselaer
- 4:15 p.m. James Kenny, Ph.D., Rensselaer (Clinical Psychologist)
- 4:30 p.m. Questions
Summary
Time allowed to view exhibits



**Section on Ophthalmology and Otolaryngology and
Indiana Academy of Ophthalmology and Otolaryngology**
(Possible Hours of Accreditation—1.0)
Room 602

12 noon Luncheon—Room 602
PRESENT AND FUTURE RELATIONSHIPS WITH GOVERNMENT PROGRAMS, Harry W. McCurdy, M.D., Washington, D.C., Executive Director, American Council of Otolaryngology
STATUS OF MALPRACTICE IN INDIANA, J. William Wright, Jr., M.D., Indianapolis

J. WILLIAM WRIGHT, JR., M.D.
Indianapolis

Certified by the American Board of Otorhinolaryngology; M.D. degree from the University of Michigan in 1942.



**Section on Surgery, Indiana Chapter, American
College of Surgeons and Indiana Chapter,
International College of Surgeons**
(Possible Hours of Accreditation 1.0)
Sheraton Room

12 noon Luncheon—Sheraton Room
SURGERY AS APPLIED TO ATHLETICS, Gerald A. O'Connor, M.D., Associate Professor of Surgery, University of Michigan, Ann Arbor
Business Meeting—Election of 1976 Section Officers



GERALD A. O'CONNOR, M.D.
Ann Arbor, Mich.

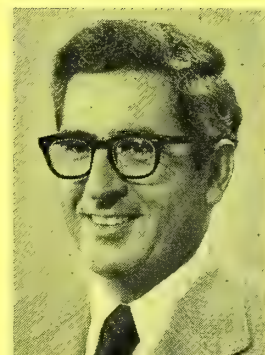
Clinical assistant professor of orthopaedic surgery, University of Michigan; team physician and orthopaedic surgeon, University of Michigan athletic teams; in 1968 received Distinguished Service Award for Exemplary Leadership in Solving Medical Problems Related to Organized Athletics in Michigan and the Nation; specialty in orthopaedic surgery; M.D. degree from Creighton University.

**Section on Preventive Medicine and Public Health and
Indiana Association of Public Health Physicians, Inc.**
(Possible Hours of Accreditation 2.0)
East Dining Room C-1

12 noon Luncheon—East Dining Room C-1
Business Meeting—Election of 1976 Section Officers
PRINCIPLES OF EPIDEMIOLOGY, Charles Barrett, M.D., Director, Division of Communicable Disease Control, Indiana State Board of Health, Indianapolis
Jerome H. Greenberg, M.D., Director, Division of Public Health, Marion County Health and Hospital Corporation, Indianapolis

JEROME H. GREENBERG, M.D.
Indianapolis

Director of public health, Health and Hospital Corporation of Marion County, Indianapolis; specialty in public health and preventive medicine; former president of the International Health Society of the United States; former member National Commission on Venereal Disease; M.D. degree from Georgetown University School of Medicine.



SPEAKERS



DAVID HOY

Author and psychic who has been described as "amazing, beyond the realm of chance, coincidence or ordinary prediction." Has been 70% right in his prediction of future happenings.

ROBERT YOUNG Bloomington

Head athletic trainer, Indiana University and supervisor of therapy, I.U. Student Health Service; vice-president of District Four, National Athletic Trainers Association; holds Master's degree in health and safety from Indiana University.



BOBBY KNIGHT Bloomington

Head basketball coach, Indiana University; former head coach at U.S. Military Academy; voted Coach-of-the-Year by UPI, Sporting News and the U. S. basketball writers in 1975; graduate of Ohio State University.

Monday, October 20, 1975

"MEET THE PROFESSOR"

(The Department of Medicine of Indiana University School of Medicine has arranged to conduct these conferences.)

Parlors A and B

- 2:00 p.m. CONCEPTS FROM THE CORONARY CARE UNIT, Joseph Noble, M.D., Associate Professor of Medicine
- 3:00 p.m. DIAGNOSIS AND TREATMENT OF INFECTIOUS DISEASES, William Hoppes, M.D., Assistant Professor of Medicine
- 3:00 p.m. Reference Committee Meetings
- 8:00 p.m. Dinner and Entertainment Program—West Dining Room
DAVID HOY—Psychic and Author, Authority in Extra Sensory Perception

Tuesday, October 21, 1975

- Breakfast Meeting
- 7:30 a.m. Meeting of Small County Delegates
Terrace Room
- 9:00 a.m. Registration continues, Convention Hall
Opening of Technical and Scientific Exhibits
Art and Hobby Show
Card Room
- 12 noon Editorial Board Meeting
Room 107

GENERAL MEETING

Sports and Medicine

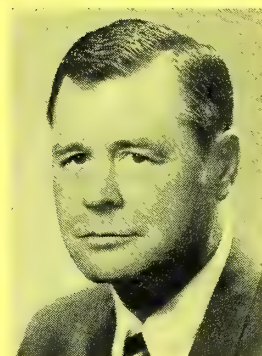
(Possible Hours of Accreditation—5.5)
Convention Hall

- 8:45 a.m. INTRODUCTORY REMARKS
Gilbert M. Wilhelmus, M.D., President, Indiana State Medical Association
Brad Bomba, M.D., Chairman, ISMA Committee on Sports and Medicine
Moderator: Leslie M. Bodnar, M.D., South Bend
- 9:00 a.m. PROTECTIVE EQUIPMENT IN SPORTS, Robert Young, Athletic Trainer, Indiana University, Bloomington
- 9:30 a.m. PHYSICAL AND PSYCHOLOGIC CONDITIONING OF THE ATHLETE, Robert Knight, Basketball Coach, Indiana University, Bloomington
- 10:00 a.m. Time allowed to visit exhibits — Coffee break
to
- 10:30 a.m.

- 10:30 a.m. THE TRAINER IN HIGH SCHOOL ATHLETICS, Pinky Newell, Trainer, Purdue University, West Lafayette
- 11:00 a.m. FLUIDS AND ELECTROLYTES IN ATHLETICS, Robert J. Murphy, M.D., Internist, Team Physician, Ohio State University, Columbus
- 11:20 a.m. QUADRICEP SYNDROME, L. William Combs, M.D., Team Physician, Purdue University, West Lafayette
- 11:40 a.m. to 12 noon PANEL DISCUSSION — QUESTION-AND-ANSWER PERIOD
- 12:30 p.m. Luncheon—Main Dining Room
PSYCHOLOGY, SUPERSTITION, MYTHS IN SPORTS, Donald L. Cooper, M.D., Director, Oklahoma State University, Stillwater, Okla.
Moderator: Garland D. Anderson, M.D., Fort Wayne
- 1:30 p.m. PERFORMANCE OF THE FEMALE IN ATHLETICS, Peter Van Handel, Ph.D., Human Performance Laboratory, Ball State University, Muncie
- 2:00 p.m. DRUGS IN ATHLETICS, Robert J. Murphy, M.D., Columbus, Ohio
- 2:30 p.m. SEX AND ATHLETICS, Donald L. Cooper, Stillwater, Okla.
- 3:00 p.m. to 3:30 p.m. Time allowed to visit exhibits — Coffee break
- 3:30 p.m. ON-THE-FIELD CARE OF THE ATHLETE, Leslie M. Bodnar, M.D., South Bend
- 4:00 p.m. IMPLICATIONS OF TITLE IX PERTAINING TO HEALTH AND SAFETY IN PUBLIC SCHOOLS, Charles Fields, Superintendent of Schools, Michigan City
- 4:30 p.m. to 5:00 p.m. PANEL DISCUSSION — QUESTIONS AND ANSWERS

WILLIAM "PINKY" NEWELL
West Lafayette

Head athletic trainer, Purdue University.



ROBERT J. MURPHY, M.D.
Columbus, Ohio

Head team physician and associate clinical professor of medicine, Ohio State University; in private practice of internal medicine; Fellow, American College of Physicians and American College of Sports Medicine; diplomate, American Board of Internal Medicine; M.D. degree from Ohio State University.



LOYAL W. COMBS, M.D.
West Lafayette

Medical director and team physician, all sports, Purdue University, 1956 to date; varsity football player, Purdue University 1939-41, most valuable 1941; played pro football for Philadelphia Eagles, 1942; M.D. degree from Marquette Medical School.



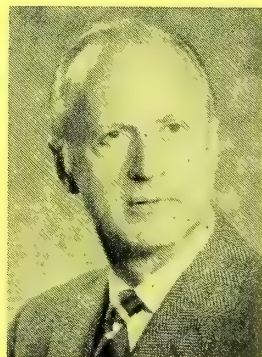
DONALD L. COOPER, M.D.
Stillwater, Okla.

Director of Oklahoma State University Health Center since 1960; member, American College of Sports Medicine; team physician, U.S. Olympic Team, XIX Olympiad, Mexico City, October 1968; medical consultant, N.S.A.A. Football Rules Committee; M.D. degree from University of Kansas School of Medicine.



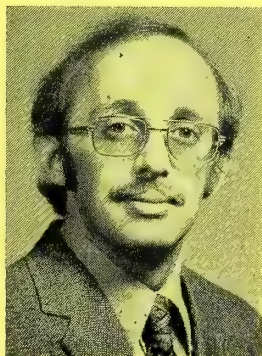
LESLIE M. BODNAR, M.D.
South Bend

Orthopaedic consultant to the University of Notre Dame athletic teams for 27 years; former secretary and now president-elect of the American Orthopaedic Society for Sports Medicine; diplomate, American Board of Orthopaedic Surgeons; Fellow of the American College of Surgeons; M.D. degree from the University of Illinois.



PETER J. VAN HANDEL, Ph.D.
Muncie

Assistant professor, Human Performance Laboratory, Ball State University School of Physical Education and Athletics; on United States Track Team, 1971; former coach of track and cross country at Kent State University; member, American College of Sports Medicine; Ph.D. degree in exercise physiology from Kent State University.



Tuesday, October 21, 1975



DAVID FROST

British TV personality who became an overnight success in the U.S. with his own talk show, a show which won two Emmy awards. An expert at social satire and pungent comedy.

- 6:15 p.m. Reception, Fifty Year Club Terrace Room
- 6:45 p.m. President's Reception, Formal Garden (courtesy of Mead Johnson Laboratories)
- 7:45 p.m. Dinner—West Dining Room
Speaker, David Frost, British TV Personality

Wednesday, October 22, 1975

- 9:00 a.m. Registration continues, Convention Hall
Opening of Technical and Scientific Exhibits
Art and Hobby Show
Card Room
- 9:00 a.m. House of Delegates Meeting
Convention Hall
(Organization meetings of Board of Trustees and Executive Committee immediately following adjournment of the House.)

THE EXHIBITS

We urge you to visit with the exhibitors—they are here to help you—and to bring you the latest information. They contribute to financing your convention.

Section on Internal Medicine, Indiana Society of Internal Medicine and American College of Physicians
(Possible Hours of Accreditation—6.0)

North Room

- 8:30 a.m. Registration
to
9:00 a.m.

Morning Session

PROBLEMS IN THE PRACTICE OF INTERNAL MEDICINE

Moderator: Thomas W. Alley, M.D., F.A.C.P., Indianapolis

- 9:00 a.m. MINIMIZING THE CHANCES OF BEING A MALPRACTICE SUIT DEFENDANT, Ralph Cohen, J. D., Indianapolis
- 9:45 a.m. EXPERIENCE WITH PEER REVIEW IN A COMMUNITY HOSPITAL, Mervin Shalowitz, M.D., Chicago
- 10:30 a.m. Time allowed to view exhibits — Coffee break
- 10:45 a.m. Address—George W. Pedigo, Jr., M.D., F.A.C.P., Louisville, ACP Representative
- 10:55 a.m. Address—Ralph F. Reinfrank, M.D., F.A.C.P., Hartford, Conn., ASIM Representative
- 11:05 a.m. Panel Discussion—WHAT LIES AHEAD IN THE PRACTICE OF MEDICINE? WILL PRACTICE BE FUN AGAIN? Moderator—George T. Lukemeyer, M.D., F.A.C.P., Indianapolis
Ralph Cohen, J.D.
Mervin Shalowitz, M.D.
George W. Pedigo, Jr., M.D.
Ralph F. Reinfrank, M.D.

- 12 noon Luncheon, West Dining Room

Afternoon Session

ADVANCES IN INTERNAL MEDICINE

Moderator: Donald W. Wood, M.D., F.A.C.P., Indianapolis

- 1:00 p.m. THE ROLE OF ECHOCARDIOGRAPHY IN CLINICAL PRACTICE, to
- 1:45 p.m. Harvey Feigenbaum, M.D., F.A.C.P., Indianapolis

1:45 p.m. WHAT WE CAN LEARN FROM
to HODGKIN'S DISEASE FOR THE
2:45 p.m. MANAGEMENT OF NON-HODG-
KIN'S LYMPHOMA, John E. Ultmann,
M.D., F.A.C.P., Chicago

2:45 p.m. Time allowed to view exhibits — Coffee
to break
3:00 p.m.

Moderator: John L. Ferry, M.D.,
F.A.C.P., Hammond

3:00 p.m. MANAGEMENT OF GRAM-NEGA-
to TIVE SEPSIS, Louise M. Riff, M.D.,
3:45 p.m. F.A.C.P., Chicago

3:45 p.m. THERAPEUTIC APPLICATION OF
to COLOSCOPY, B. H. Gerald Rogers,
4:30 p.m. M.D., Chicago
Election of 1976 Section Officers.

Section on Urology and Indiana State Urological Society
Terrace Room
(Possible Hours of Accreditation—3.5)

8:00 a.m. CUTANEOUS URETEROSTOMY,
to Chester C. Winter, M.D., Professor and
9:00 a.m. Director, Division of Urology, Ohio State
University, Columbus
Discussion

9:30 a.m. RADICAL RETROPUBIC PROSTA-
to TECTOMY, Neale A. Moosey, M.D.,
10:00 a.m. Indianapolis

10:00 a.m. Discussion
to
10:15 a.m.

10:15 a.m. A CASE OF BILATERAL ADRENAL
to HYPERPLASIA AND ITS INVESTI-
10:45 a.m. GATION, Ned P. Rule, M.D., Evansville

10:45 a.m. Discussion
to
11:00 a.m.

11:00 a.m. EXPERIENCE WITH TESTICULAR
to SCANNING WITH TECHNESIUM 199,
11:20 a.m. Daniel M. Newman, M.D., Indianapolis

11:30 a.m. Discussion
to
11:45 a.m.

JOHN E. ULTMANN, M.D.
Chicago

Professor of medicine, The University
of Chicago; director of Clinical On-
cology, the Franklin McLean Research
Institute; director, University of Chi-
cago Cancer Research Center; M.D.
degree from Columbia University.



B. H. GERALD ROGERS, M.D.
Chicago

Teaches flexible fiberoptic coloscopy
at the University of Chicago; specialty
in gastroenterology; member of
American College of Physicians; M.D.
degree from the University of Chicago
School of Medicine.

CHESTER C. WINTER, M.D.
Columbus, Ohio

Professor of surgery and urology,
Ohio State University; certified,
American Board of Urology; Fellow,
American College of Surgeons and
American Academy of Pediatrics;
M.D. degree from State University of
Iowa.





THOMAS E. HAYHURST, M.D.
Fort Wayne

Medical consultant to the Board of Directors of the American Lung Association of Northeastern Indiana; board certified in Internal Medicine and Pulmonary Diseases; M.D. degree from Indiana University School of Medicine in 1967.

JAMES B. NELSON, M.D.
Fort Wayne

In private practice; specialty in allergy; member, American Academy of Allergy and American College of Physicians; M.D. degree from University of Michigan Medical School.



IRVIN CAPLIN, M.D.
Indianapolis

Associate Professor, Department of Pediatrics, I.U. School of Medicine, and Director of Allergy Clinic, Riley Hospital; diplomate, American Board of Allergy and Immunology and American Board of Clinical Immunology and Allergy; Fellow, American Academy of Allergy and American College of Allergy; M.D. degree from I.U. in 1939.



JOHN T. HAYNES, M.D.
Indianapolis

Clinical associate professor, Department of Pediatrics, Indiana University School of Medicine; diplomate, American Board of Allergy and Immunology; Fellow, American Academy of Allergy and American College of Allergists; M.D. degree from Indiana University School of Medicine.



- 11:45 a.m. Pyelogram Conference
to
12:30 p.m.
12:30 p.m. Business Meeting—Election of 1976 Section Officers
12:45 p.m. Informal luncheon (Dutch)—Main Dining Room

Section on Allergy and Immunology
(Possible Hours of Accreditation — 3.0)
Roost Room

- 12 noon Luncheon—Roost Room
12:30 p.m. BRONCHIAL ASTHMA AS SEEN BY A PULMONARY DISEASE SPECIALIST, Thomas E. Hayhurst, M.D., Fort Wayne
1:00 p.m. HEREDITARY ANGIOEDEMA—Case Reports, James B. Nelson, M.D., Fort Wayne
1:30 p.m. EPINEPHERIN — INSULIN ANTAGONISM IN A DIABETIC ASTHMATIC, Irvin Caplin, M.D., Indianapolis
2:00 p.m. EXPERIENCE WITH NEW BETA-2 ADRENERGICS, John T. Haynes, M.D., Indianapolis
2:30 p.m. UNDESIRABLE REACTIONS TO CROMALYN SODIUM, James K. Hill, M.D., Indianapolis
Business Meeting — Election of 1976 section officers

Section on Radiology and Indiana Roentgen Society
(Possible Hourse of Accreditation — 1.0)
Sheraton Room

- 10:00 a.m. Executive Committee Meeting
12 noon Luncheon—Sheraton Room

ROENTGEN FINDINGS IN SPORTS INJURY

Films are to be brought by participants and the discussion will be led by Roscoe E. Miller, M.D., Indianapolis, professor of radiology, Indiana University School of Medicine

Program—Woman's Auxiliary to the Indiana State Medical Association

President—Mrs. Edsel Reed, Jeffersonville

General Chairman of Women's Activities—Mrs. James A. Marvel, Evansville

Program Chairman—Mrs. Abner Bennett, southern area vice-president, Evansville

Publicity Chairman—Mrs. Robert Kincaid, Evansville

Sports Co-ordinator—

Reservations—Mrs. James A. Marvel, Evansville

Sunday Afternoon, October 19, 1975

10:00 a.m. Golf and Tennis Tournaments
Golf Tourney on Lower Course

Monday, October 20, 1975

9:30 a.m. Registration and Hospitality, Room A, Mezzanine
Art and Hobby Show
Card Room

10:00 a.m. Open Board Meeting
Room A, Balcony

12:30 p.m. Auxiliary Luncheon
West Dining Room
Entertainment "WOW"

2:30 p.m. CARDIAC PULMONARY RESUSCITATION DEMONSTRATION by American Heart Association

8:00 p.m. Dinner and Entertainment:
West Dining Room
ESpecially, David Hoy, psychic and author

Tuesday, October 21, 1975

9:00 a.m. Art and Hobby Show
Card Room

10:00 a.m. Orientation of hotel recreational facilities by hotel staff member, Hotel lobby

1:30 p.m. General Meeting, Sports and Medicine
to
Convention Hall

5:00 p.m. PERFORMANCE OF THE FEMALE IN ATHLETICS
Other topics which may be of interest to women

6:45 p.m. President's Reception, Formal Garden (Courtesy of Mead Johnson Laboratories)

7:45 p.m. Dinner—West Dining Room
Speaker, David Frost, British TV Personality

Wednesday, October 22, 1975

Free time to enjoy hotel recreational facilities.
Available continuously — American Indian Jewelry Booth (proceeds for AMA-ERF) by Mrs. James E. Benson, Elkhart, AMA-ERF Chairman

Reports of Officers

Executive Secretary

In accordance with the directive of the House of Delegates and the Constitution and Bylaws, your secretary lists herewith the disposition of actions taken by the 1974 Meetings of the House of Delegates, Indiana State Medical Association.

Actions of the 1974 House of Delegates and Disposition:

RESOLUTION 74-1

Resolved, that the Indiana State Medical Association again prepare and seek to have introduced into the General Assembly a bill defining the term "physician" as applying only to persons holding the academic degree of Doctor of Medicine, or Doctor of Osteopathy.

ACTION:

Legislation to define the word "physician" was included in the Medical Practice Act, Chapter I—Definitions and Exclusions, Item (g) which reads "physician" means any person who holds the degree of doctor of medicine or doctor of osteopathy or its equivalent and who holds a valid unlimited license to practice medicine or osteopathic medicine in the state of Indiana . . .

RESOLUTION 74-6

This resolution was substituted in lieu of Resolutions 74-7, 74-8, 74-9, 74-14, and 74-22, as amended, and referred to the President of the Indiana State Medical Association. The resolution had to do with parliamentary maneuvering by the AMA leadership to prevent a floor debate of a PSRO recommendation. It was resolved that a letter express disapproval of the lack of free debate on the floor of the House of Delegates of the AMA be written by the President of the ISMA.

ACTION:

This was accomplished.

RESOLUTION 74-11

Resolved, that ISMA schedule its annual meeting so that the scientific sessions not conflict with business meetings and also resolved that negotiations be initiated with the Indiana Academy of Family Physicians, the various other state specialty societies and the Indiana University School of Medicine to develop a coordinated scientific and educational annual program of meetings during one period of time . . .

ACTION:

There was no action taken on these matters.

RESOLUTION 74-12

This resolution dealt with the creation of a section on clinical pharmacology and therapeutics. The House did not adopt the creation of this section until such an organizational program could be presented to the 1975 House of Delegates:

ACTION:

No program received as of August 1, 1975.

RESOLUTION 74-16

Dealt with proposals for national licensure and periodic relicensure of physicians as now being advanced in the Congress and asked that the ISMA communicate concerns embodied in the resolution to all candidates for the State General Assembly and national Congress and regularly remind these legislators of such concerns and that the ISMA delegation to the American Medical Association sponsor appropriate measures to see that the matter of evaluation of competency be implemented.

ACTION:

Matter brought to the attention of the Board at the June 8 meeting by the chairman, and no action was taken.

RESOLUTION 74-17

Resolved that Indiana State Medical Association affirm the professional correctness of interest charges imposed on overdue medical bills and instruct the delegates to the AMA to express this sentiment to the national organization.

ACTION:

Such a Resolution labeled C 74-5 was introduced before the AMA. The Reference Committee recommended that the resolution not be adopted and recommended adoption of the Judicial Council Report D in lieu thereof. The House adopted the following: "It is not in the best interest of the public or the profession to charge interest on an unpaid bill . . ." It is not improper, however, for a physician to add a service charge, equal to the actual administrative cost of rebilling, on accounts not paid within a reasonable time. Patients must be notified in advance of the existence of this practice.

RESOLUTION 74-20

This resolution referred to the Board of Trustees pertained to safeguards on data handling, pointing out that access to stored patient data be absolutely determined by physicians accountable to the Indiana State Medical Association.

ACTION:

In conjunction with the development of I-MEDIC, it was brought to the attention of the Board the intent of 74-20 and it was further pointed out that I-MEDIC is in the spirit of compliance with 74-20. The Board is currently proceeding with the development of I-MEDIC.

RESOLUTION 74-25

Pertains to medical liability insurance, its unavailability, and instructions to the Board of Trustees to work with the presidentially appointed ad hoc committee to gather information with recommendations within thirty days to be acted upon definitely at a special open meeting of the Board within sixty days.

ACTION:

The president and the Board carried out this responsibility.

RESOLUTION 74-27

Revision of Blue Cross-Blue Shield regions. This resolution was referred to the committee on insurance. It stated that the system of multiple areas with varying fees for similar services be abolished and that benefits become uniform and a single schedule of payments applied to the entire state.

ACTION:

There was no action taken by the Commission on Medical Economics and Insurance. The Board, however, at its Jan. 18, 1975, meeting passed a motion requesting Blue Shield to review the matter of dividing the state into separate economic areas for fee payment.

EXPANSION OF EXISTING HEAD-QUARTERS BUILDING

The House adopted the portion of this report providing space for storage and non-ISMA operation in the Association rental properties. The report spoke of moving the CHAMPUS Department and Tel-Med out of the existing building into one of the rental properties.

ACTION:

This has not been accomplished. The Executive Committee has, however, worked through the year on rezoning and preparation of one of the residences for the move.

FUTURE PLANNING COMMITTEE

The House adopted the Future Planning Committee report with that portion concerning optional one-day meeting referred to the Board of Trustees and that portion on restructuring of committees and commissions referred to the Commission on Constitution and Bylaws, to be voted on by the 1975 House of Delegates.

ACTION:

Restructuring of commissions and committees was considered by the Commission on Constitution and Bylaws. An attorney was authorized by the commission to prepare a report with appropriate wording to make these changes.

STUDENT LOAN COMMITTEE

The report was referred to the Board of Trustees with the following options to be considered: (1) Restructure of the committee, (2) transfer the loan money to the AMA-ERF, and (3) discontinue the fund and/or billing for this loan committee.

ACTION:

A tentative agreement has been arrived at which would bring the ISMA student loan fund to almost parallel requirements with that of the AMA-ERF. (See Student Loan Committee Annual Report.)

COMMISSION ON CONSTITUTION AND BYLAWS

The House referred to the Commission on Constitution and Bylaws a suggestion to incorporate the following sentence under Chapter VI—Duties of Officers: "The duties of the Speaker will be patterned after those performed by the Speaker of the AMA House of Delegates."

ACTION:

The commission discussed duties of the Speaker of the House of Delegates. It was the opinion of the commission that the operation of the House of Delegates should be strictly left to the Speaker of the House. This recommendation is to be made in the commission's report to the House of Delegates.

COMMISSION ON LEGISLATION

The House adopted the commission's report and referred the portion concerning the Medical Practice Act to the Commission on Medical Education and Licensure for final perusal and to the Commission on Legislation for implementation.

ACTION:

This was accomplished and the State Legislature passed the new Medical Practice Act.

COMMISSION ON PUBLIC INFORMATION

The House recommended that Tel-Med be continued until funds run out or outside funding is found.

ACTION:

Tel-Med, since the action of the House, has received additional grants from RMP and from Blue Shield. The Board of Trustees is currently seeking additional sources.

COMMISSION ON VOLUNTARY HEALTH AGENCIES

The House stated that further consideration be given to establish a mechanism whereby local agencies may be approved by county societies and thereby receive approval of the Indiana State Medical Association.

ACTION:

There was no action taken on this matter during 1974-75, but in previous action of the commission, it was expressed that ISMA could not survey and approve all of the local units of the statewide voluntary health agencies. In the past the commission has encouraged local societies to establish criteria for local voluntary health agency units.

The following highlights some of the many activities of the ISMA Headquarters Staff which are carried out on an ongoing basis year after year.

PATIENT'S COMPENSATION ACT

The one subject which is predominant is the passage of H.B. 1460, the Patient's Compensation Act.

Along with the strategic planning by the president, the committees and the Board of Trustees was the supportive action of the ISMA staff working diligently side by side with the leadership of the Association to accomplish a goal which was achieved in spite of countless hurdles and potential pitfalls.

During the course of action in passing the bill, hundreds of calls were received from all over the country—from medical society officers, staff personnel, and interested individuals—asking for the latest information, copies of the law, facts on promotion in the public press, approach to legislators, lobbying activity, financing, and overall strategy.

This Act has been heralded throughout the nation as a monumental achievement and an important landmark in the field of legislation.

CME ACCREDITATION PROGRAM

The accreditation of continuing medical education activities by hospitals, county medical societies, specialty groups, and allied health organizations, continues to grow in volume as more of these groups have become aware of the value of such accreditation to the individual member of the Association.

The ISMA was a leader in the country in receiving approval from the AMA in evaluating these programs. Behind the scenes of such activity are the endless volume of correspondence, the planning for site team visits, meetings of committees, and other details carried out by your staff.

PRECEPTORSHIP PROGRAM

An important continuing program is the preceptor screening function of the ISMA headquarters working in conjunction with the Preceptor Committee and the Indiana University Department of Family Practice. This program provides for senior medical students to spend time at the elbow of a practicing physician in learning the applied skills of medical care. It is a highly successful endeavor and is sought by the medical student in his quest to understand more about his chosen profession.

THE ANNUAL RETREAT

The Annual Retreat, conducted by the ISMA in cooperation with the faculty at Indiana University School of Medicine and students from all of the classes (freshman through senior), is also a successful, continuing program. This past year the sixth Retreat was held at the Brown County Inn. Approximately 80

participate each year in a two-day "rap session" which because of its casual informality results in a closer working relationship between the practicing physicians of Indiana, the faculty, and the student group.

SPEAKERS' BUREAU

The Speakers' Bureau of the ISMA will have completed one year of activity and is being utilized extensively. Many requests for speakers to appear before such organizations as Rotary, Kiwanis, Optimist groups, etc. are channeled through the ISMA headquarters to the coordinators of the program, the Hopkins Syndicate, Inc. in Melloott, Indiana. The speakers' subjects include: "The Future of Freedom," "Crisis, Crisis, Crisis," "America As I See It," "Freedom of Choice," "Beware of the Trojan Horse," "America's Still the Promised Land," "Let's Fulfill America's Dream," and "Beware of Big Brother."

AWARDS

This year also marked the greatest number of applications from Indiana's press, radio and television stations in competition for the three awards given each year by the Association for outstanding reporting and writing on medical subjects. Initiated in 1963, the awards program has grown in stature with the communications media and has attracted in growing numbers the attention of fine reporters and writers. Application forms for all the media and for county medical societies are sent continuously at the first of the year and upon receipt are reviewed by the Commission on Public Information, who make the selections.

Also widely sought is the Physician Community Service Award, which is given to one member a year for his voluntary contribution of time and effort to community projects not necessarily related to the medical profession and its activities.

EMERGENCY MEDICAL SERVICE

Since the organization of the Governor's Commission on Emergency Medical Service, the ISMA Commission on EMS has established a close working relationship with the executive director of the Governor's Commission, Mr. Philip Martin, and the chairman of the Governor's Commission, Dr. James Dillon. All members of the ISMA commission are kept informed by Mr. Martin on the Governor's Commission activities, currently concentrating its efforts on training ambulance technicians and on setting up a good system of communications throughout the state. The Headquarters has worked closely with Mr. Martin's staff in the provision of booklets, leaflets, and policy statements on EMS from the ISMA, the AMA, the federal government and other bodies currently concerned with emergency medical service.

INFORMATION REQUESTS

Your Headquarters is constantly called upon for information and assistance—the range of which is wide and varied. This might include putting a television news reporter in touch with an appropriate spokesman on a given subject to providing a student with the history and background of medical opposition to socialized medicine, or providing information of policy on acupuncture, abortion, Medicaid, Medicare, venereal disease, or utilization review.

TEL-MED

Tel-Med is headquartered and staffed in the offices of ISMA and is open for calls six days a week. The program attracts callers from throughout the state and the library continues to grow with the addition of new tapes on an ever-increasing variety of medical subjects. From March, 1973, through June, 1975, Tel-Med has received 313,823 calls. The overall average number of calls per day computed in June was 193 for Marion County local calls and 311 for the state-wide WATS.

CHAMPUS

Your Association continues to administer the CHAMPUS program and has since its inception in 1957.

The administration of the Indiana program continues to receive the plaudits of the Federal Government. Of all the fiscal administrators, the Indiana administrative cost is the lowest in the nation. The Indiana cost for processing a claim is \$2.88 per claim. The highest cost in the nation is \$14.14, and the national average is \$6.47 per claim. For the period April 1, 1974, through March 31, 1975, we have paid a total of 24,625 claims to physicians who have received \$2,067,823.

The fear that we had a year ago that they were going to revise the CHAMPUS program into a program similar to Medicare has been postponed, according to federal sources. With the flow of claims increasing, it now requires a full time staff of six persons. The CHAMPUS department will be moved, and may have been moved by the time you receive this report to 3942 North Pennsylvania Street.

COMMUNITY/PHYSICIAN PLACEMENT

The Association's membership department continues to act as a clearing house for physicians and communities needing contacts for mutual consideration of placement in both rural and urban areas.

MEMBERSHIP DEPARTMENT

The membership department of the Association entered into the computer

age during this year by converting its membership files into the American Medical Computer Assistance Program (AM-CAP). Through this system the ISMA now has available to the membership department a record entitled "Physician Profile Record Card."

The ISMA file under the new combined computer system now contains records on 5,050 Indiana physicians with approximately 300 non-members included in this number.

Under the system, the files on Indiana physicians are updated daily with such information as address changes, transfers of membership and dates and status of deceased members.

Dues bills to members are also handled through the AM-CAP program. The system also provides fast service on mailing labels for the Association in instances of promoting the ISMA convention, mailing the Newsflashes, and for mailings to specific district medical societies.

The system has great potential in the future for maintaining continuing medical education records of ISMA members, convention attendance information and other data.

COMMISSIONS AND COMMITTEES

Commissions and committees of the Association probably occupy the major part of the staff and Headquarters operation.

This involves arranging for meetings, sending out notices, keeping accurate records of attendance and terms for members on each commission, writing and circulating minutes, and doing the follow-up work as directed by the commissions. The staff also maintains files on commission activities, refers to appropriate commissions the information which is channeled into the headquarters from hundreds of sources involved in some field of health.

LIAISON WITH THE WOMAN'S AUXILIARY

The Auxiliary meets routinely in the Headquarters office throughout the year. The staff also assists the Auxiliary by providing them with legislative information, membership information, circulating leaflets and booklets, assisting them with requests for information and with the promotion of their meetings. The Auxiliary utilizes the mechanical equipment in the office as well as the WATS line of the Association to maintain rapid communication with their county auxiliaries when needed.

LIAISON WITH ALLIED HEALTH GROUPS

Utilizing the Headquarters for meetings during the past year, with all of these activities supported in part through Headquarters staff participation, were the Board and Executive Committee of

Regional Medical Programs, the Research Projects Allocation Committee of the Indiana Division of the American Heart Association, as well as various specialty societies and allied health groups.

The Association comes very close to operating on a continuous seven-day schedule with the operation of Tel-Med on Saturdays, meetings of the commissions on Sundays, and at least two or three meetings of subcommittees and other groups during the week.

CONVENTION PLANNING

Working in close conjunction with the Commission on Convention Arrangements, the planning of the convention constitutes involvement of the Headquarters staff in scheduling meetings, arranging for speakers' arrivals, departures, and hotel accommodations, providing speakers with needed audio-visual equipment, arranging for lunches and dinners, planning registration procedures, typing reference committee reports, promoting the meeting, duplicating the paperwork for the business session of the convention, handling individual housing, arranging press conferences, handling individual requests of newsmen for information, working with exhibitors, and generally seeing that the convention functions smoothly and efficiently.

FIELD SERVICE

The field staff of the Association continued to call on individual members of the Association and county society officers, and concentrated on contacting new members of the Association with information on the services of ISMA. They attended county society meetings throughout the year, assisting the membership in a variety of ways and also assisted in the planning of the annual meetings of the district medical societies.

During the sessions of the Indiana legislature, both field men served as the eyes and ears of the Association in observing the activities of the Senate and House of Representatives and reported these observations to the executive secretary and to the Commission on Legislation. Throughout the year they maintained close personal contact with Indiana legislators at their homes and businesses.

As part of their legislative operation they accompanied the Executive Committee on its annual journey to Washington, D.C., to meet with the Indiana congressmen and senators.

The field staff also assists the Headquarters staff from time to time on specific projects.

INTERNATIONAL TRAVEL COORDINATION

The ISMA Headquarters staff serves as coordinator for international trips sponsored by two travel agencies, INTRAV and MARITZ. The staff co-

ordinates the mailings announcing the trips to the membership, receives the reservations and deposits from those planning to attend, and answers numerous questions concerning details of each trip.

These trips have been highly successful. In 1975, 140 Indiana physicians and their wives traveled to Rabat, Casablanca, Marrakech, Tangier, Nairobi, Mount Kilimanjaro, Belgium, Germany, France, Switzerland, and a four-day cruise on the Rhine River.

September 1, another group of 70 members and wives will tour the Balkans, including Bucharest, Istanbul, and Dubrovnik with an optional one-day trip to Kiev, Russia.

SECRETARIAL SERVICE

The headquarters office also transcribes hundreds of pages of minutes for county medical societies throughout the year; and following the direction of the county society secretary, distributes these reports to the appropriate members. These minutes, as well as countless letters and memoranda, are received on the WATS line and placed on tape by the physician-members.

The staff also serves as secretarial force for the officers and Board of the Association in their need for continuing communication with the membership and with other medical organizations, both statewide and national in scope.

Although this can only reflect a partial list of the Headquarters and field staff functions, this report will serve to illustrate the dedication of the staff in any and many endeavors, working to carry out the business of ISMA through the direction of the commissions and committees, the Board of Trustees and the Executive Committee.

As one looks back over the past years, every physician in the state of Indiana has a right to be proud of the activities of this Association. It is impossible to convey to individual members the daily activities of your headquarters and the officers in handling the many problems that confront the organization. The past year has been a fruitful one in attempting to resolve the serious problem of professional liability. It will, no doubt, be at least three years before we know whether we have resolved it. Undoubtedly, there will be efforts made to change the law during the coming years, but I am sure the Association and its committees and officers will do everything in their power to completely resolve the issue to the satisfaction of all.

The coming months and the coming years are going to present many serious challenges to this organization and its members. We have seen in the early 1950s and in 1975 a show of strength by the profession when it gets behind a common cause and "puts its shoulder to the wheel." We have proven that we

are effective when we work together. The coming months and years are going to require this type of cooperation and effort if medicine is to achieve its goals. We are going to see more and more attempted federal intervention into the health care field. It is something that all must be alert to, or else we will forfeit all basic tenets upon which the medical profession is founded.

In keeping up with the trends of the future, if we are to provide the services which are due the members, and if we are to develop strong, effective programs—if this is the desire of the membership, then some thought must be given to additional funding and adequate staff to handle these various responsibilities.

The Indiana State Medical Association has a bright future ahead, and I would hope that the Future Planning Committee and the officers of the Association give serious thought to the future of the Association.

I cannot help but comment that the officers and trustees of this Association have been and are dedicated, willing men who have given their all to advance the Association to its present place, nor can I omit an expression of thanks to the loyal staff which serves you in the headquarters office. Many of them have gone beyond the call of duty in order to accomplish those things which have been accomplished.

JAMES A. WAGGENER
Executive Secretary

Chairman of the Board

The Board of Trustees held an organizational meeting following the annual convention on Oct. 8, 1974, at approximately 4:30 p.m.

At this meeting new additions to the Board of Trustees were welcomed, as follows: Dr. Alvin J. Haley, Fort Wayne, elected trustee of the 12th District to fill the unexpired term of John S. Farquhar, Jr., who resigned. Dr. Martin J. O'Neill, Valparaiso, was welcomed as the new trustee for the 10th District, elected in 1974. The four trustees who were reelected and welcomed back were: Dr. Bernard B. Rosenblatt, Evansville, 1st District; Dr. Howard C. Jackson, Madison, 4th District; Dr. John O. Butler, Indianapolis, 7th District; Dr. G. Beach Gattman, Elkhart, 13th District.

Other men welcomed to the Board functions were two men elected alternate trustee: Dr. Edgar E. Cantwell, Vincennes, 2nd District; and Dr. Franklin A. Bryan, Fort Wayne, 12th District. Four previous alternate trustees had been reelected in 1974 and were welcomed back: Dr. Thomas Neathamer, 3rd District; Dr. Donald C. McCallum, Indianapolis, 7th District; Dr. Max N. Hoffman, Cov-

ington, 9th District; Dr. Lloyd L. Hill, Peru, 11th District.

The business of the organizational meeting of the Board was then carried out, with the election of the chairman being the first order of business. The meeting was opened by President Wilhelmus, chairing the meeting temporarily. Ballots were passed out and the election was concluded with Dr. Richard Ingram, Montpelier, 8th District, being elected chairman of the Board.

Further business included the election of two members to the Executive Committee of the Board. These members were Dr. Donald Kerr, Bedford, reelected; and Dr. William Clark, Fort Wayne, reelected.

That concluded the business of the organizational meeting of the Board and the meeting was adjourned.

The next meeting of the Board was called for Sat., Nov. 23, and Sun., Nov. 24, 1974. One of the big problems for action stemmed from the October 1974 meeting of the House of Delegates—consideration of the medical liability insurance problem in the state of Indiana. During the 1974 annual meeting there was a meeting of a special reference committee. This reference committee made specific medical liability recommendations which were adopted by the House of Delegates in the form of the following resolution:

"Resolved, that the House instruct the Board of Trustees to work with a presidentially appointed ad hoc committee to gather information and come forth with recommendations within 30 days to be acted upon definitely at a special open meeting of the Board of Trustees within 60 days; and further, be it resolved, that a dues increase of \$10, payable one time, be marked to fund the publicity and legal activity."

Acting under the direction of this resolution, the Board did schedule the two-day session, Nov. 23-24, with the main item of business the discussion of the medical liability problem. The meeting on Sun., Nov. 24, was attended by the Board and by approximately 120 physician-members—all vitally interested in the crucial question of medical malpractice and insurance coverage.

During the course of the meeting, a Patients' Compensation Act (prepared by Mr. James Stewart, attorney for the Indiana State Medical Association, in conjunction with several Indianapolis attorneys was read and explained to the group. Discussion followed and, on a motion by Dr. Ferrara it was approved that the Patients' Compensation Act would be introduced into the 1975 legislature.

Further business for the day included a continuation of the president's Ad Hoc Committee on Medical Liability, under his direction, for the purpose of investi-

gating alternative solutions to the medical liability problem in Indiana. One suggestion was to search for a carrier who would be willing to write a state-sponsored medical liability program. There was much discussion concerning this and the continuation and power of the ad hoc committee; however, ultimately it was decided that the committee would have the power to interview multiple carriers for the possibility of a state-sponsored plan and, if satisfactory propositions were offered, to present them to the Board for a final decision.

In addition to these two major items of business, a motion was passed to instruct our Speakers' Bureau to include speakers, fully and thoroughly acquainted with the subject of medical liability in Indiana, to address the subject when requested.

There being no further business, the Board adjourned with the next meeting scheduled for January 1975.

The Board convened for a two-day session on Sat., Jan. 18, and Sun., Jan. 19, 1975.

President Wilhelmus announced to the Board that Robert Mahowald, former senator in the state legislature, had been employed as lobbyist for the ISMA and would be working with the Commission on Legislation.

Reporting on insurance coverage possibilities, Dr. William Cast, chairman of the ISMA's Committee on Medical Liability Insurance, told the Board that the committee had heard a proposal for a cooperative plan with ARM Insurance, a federation of 16 independent insurance agencies who have agreed to market cooperatively a product throughout the state of Indiana. Dr. Cast detailed the plan as placed before them and said the ARM group agreed to hear the committee's objections and to return with more firm proposals. On motion of the Board, Dr. Cast's committee report was accepted. Further substance of this committee report stated "that the claims-made concept, which, while an actuarial device for the insurance company, could not be accepted by the medical profession without the presence of control by the Insurance Commissioner, a responsible insurance industry operating in an atmosphere of competition, and without the provisions of contractual guarantee for future coverage at guaranteed premium costs." The committee also submitted a resolution concerning "claims-made" type policies. The Board moved that the Insurance Commissioner of Indiana be informed of adoption of the report and of its substance.

On motion of the Board, Dr. Lowell Steen, Hammond, was supported by the Board in his bid for election as an AMA trustee in June 1975. Alvin J. Haley, M.D., Fort Wayne, and Wei Ping Loh, M.D., Gary, were reelected to the Editorial Board of *The Journal*; and re-

lected to the Board of the Indiana Medical Education Foundation for two-year terms were Drs. Lester D. Bibler, Indianapolis, and Bernard Hall, Logansport. For three-year terms were Drs. Jack H. Hall, Indianapolis, and Joe Dukes, Dugger. Renominated to the Blue Shield Board were Drs. Wilbert McIntosh and Maurice E. Glock, both for three-year terms, and Peter E. Gutierrez for a two-year term.

Chairman of the Blue Shield Board, Dr. Joe Black, reported on activities of the Board over the past months and complimented the physicians nominated by ISMA for their attendance and interest. Speaking to the financial difficulties of Tel-Med (telephone health information service to the public), he said that Blue Shield would make available to ISMA \$25,000 plus \$5,000 for additional tapes, updating, etc., to continue operation but that Blue Shield would like to advise a more reasonable financing for the operation. The Board moved (1) to accept the \$25,000 and the additional \$5,000 and (2) that the Tel-Med Committee communicate with Blue Shield to study better utilization.

It was reported to the Board that the AMA would go to court in an attempt to prevent the federal government from implementing the National Health Planning and Resources Development Act, a law replacing the Comprehensive Health Planning Program and the Regional Medical Programs. The Board approved that a letter of commendation be sent to the AMA for this action.

Reporting on further activities by the AMA, Dr. James Harshman, floor leader of the AMA Delegation, said the House approved a \$60 assessment per member for 1975. The ISMA Delegation opposed all of the special assessment motions and also opposed a recommendation, eventually defeated, that the dues be increased by \$90, effective Jan. 1, 1976.

Discussed at great length was the restructuring of ISMA commissions and committees, as posed in the report of the Future Planning Committee. The Committee's recommendations closely parallel the internal council structure of the AMA. Opinion was expressed that the present structure was antiquated and that reducing memberships under the newly proposed plan would not necessarily negate greater participation since subcommittees could be named under each new commission to consider special problems. The Board passed two motions: (1) that the Future Planning Committee report on the commission/committee restructuring be referred to the Commission on Constitution and Bylaws for implementation in conference with the Future Planning Committee, and (2) that one member from each district medical society be placed on the each commission.

Also discussed by the Board, as a direct result of efforts of smaller areas to get more physicians, was the subject of fees being lowered for physicians moving from a large urban area. The Board adopted a motion that a request be made to Blue Shield to look into the problem of physician distribution, variances in fees, and the division of the state into two fee areas.

Adopted was a resolution on discrimination, transmitted from the Fort Wayne Medical Society. The resolution read:

"Be it resolved, that the Indiana State Medical Association shall continue to extend to all its members equal protection and that no rights, privileges, or obligations of its members shall be abridged on the basis of sex, race, color, creed, national origin, or school of medicine."

The meeting was adjourned to convene on Mar. 9, 1975.

At the Mar. 9 meeting, President-elect Vincent Santare reported to the Board that House Bill 1460, Patients' Compensation Act, had passed on second reading before the House of Representatives and that the Medical Practice Act (minus the physician-assistant portion) had passed the third reading in the House.

Two resolutions from Vanderburgh County Medical Society were referred, without recommendation, to the 1975 House of Delegates. One having to do with air travel costs asks that reimbursement be made at tourist or economy rates unless some physical ailment of the traveler makes this inadvisable or in cases of emergency when other accommodations are not available. It also urges the Indiana Delegation to the AMA be instructed to work for the adoption of a similar policy at the AMA level. The resolve of the other resolution states that until such time as the Association's resources permit the luxury of travel and transportation of staff and equipment, all meetings be held in Chicago, except for government-related activities which may be better served by a Washington location. The latter resolution also states that scheduled sessions at distant sites be rescheduled for Chicago unless compelling and persuasive reasons can be advanced with appropriate fiscal data.

Discussed by the Board were automobile insurance company forms asking for medical information about persons over 65 years of age and their capability to drive an automobile. The Board reaffirmed the action of the 1968 House of Delegates in Resolution 68-20B which states that while physicians are "willing to submit data and do appropriate examinations, they believe that questions of driving ability and insurability should rest with the insurance company instead of with the physician." The Board further directed that the 1968 resolution be cir-

culated to the county medical societies and to the Insurance Commissioner of Indiana with a request for a reply from the Insurance Commissioner.

The Board approved appropriate memorial of deceased past presidents at the first meeting of the House following death. The trustee from the deceased president's district is to see that appropriate recognition is planned.

The Board was informed that Winona Memorial Hospital, Indianapolis, had been selected for pilot study under I-MEDIC. The hospital accepted after hearing a presentation of Dr. Peter Petrich and a representative of ROCOM (an Ohio-based computer system) on how such a peer review system would function. The original time for the pilot study of the effectiveness of a system was set for 90 days; but, on motion of the Board, it was extended for a six-month period. I-MEDIC was referred to as a viable independent alternative to PSRO.

For an appointment to the Judicial Council of the AMA, Dr. Donald E. Wood, Indianapolis, received the Board's support.

Also supported by the Board was the statement of Malcolm C. Todd, M.D., president of the AMA, concerning opposition to new hospital utilization review regulations. Dr. Todd, in announcing the filing of the lawsuit against the Department of HEW, said, "This is the first time we of the American Medical Association have taken legal action against HEW. It may not be the last. We serve notice now that we will oppose every attempt by the government to interfere between a physician and his or her patient."

To carry out the objectives of the Interprofessional Relations Commission action, which arose from current discussions between attorneys and physicians on professional liability, law suits and legislation, the Board discussed expanding the Medical-Legal Review Committee. By an adopted motion the Board requests the House of Delegates, through the Commission on Constitution and By-laws, that the Medical-Legal Review Committee be directed to have minimally three members each from the ISMA and from the State Bar Association.

Health planning regions under Public Law 93-641 were aired by the Board. In a letter to Governor Bowen the Board had pointed out that ISMA had studied a similar proposal in 1965 and that 14 regions, which were then developed, have been since used for health planning and practically all other programs of a similar nature. The letter further pointed out that these regions do not conform to PSRO areas, which were arbitrarily established by HEW. The Board moved that the Governor be advised to develop areas for P.L. 93-641 along the same regional boundaries, or combinations thereof, and that conjoining relationships

by counties with other states be avoided because of past unpleasant experiences in early attempts at crossing state boundaries.

The meeting was adjourned to meet again on May 4, 1975.

At the May meeting President Wilhelmus reported that the new Medical Practice Act, minus the physician-assistant portion, had passed and that the Governor had vetoed the foreign physician bill which would have allowed these doctors to practice in Indiana without taking the same examination taken by Indiana University graduates. Discussing H.B. 1460, the Patients' Compensation Act, President Wilhelmus detailed for the Board the inside story of the activities of his special committee. Because of numerous requests from members asking for clarification and guidance, the Board moved that a letter be sent to all members to explain the salient points of the law and the implications on insurance coverages, malpractice suits pending, statute of limitations and other points of concern to the physician. The effective date of the law—July 1, 1975.

Mr. William J. Davey, vice president of the Medical Protective Insurance Company, Fort Wayne, also reported to the Board that his company will be writing more business which will be occurrence policies; and as to why insurance carriers are limited in the number of insureds, he said this is regulated by law, inasmuch as the total premiums received by a company cannot exceed three times its capital structure.

As a result in the passage of H.B. 1460, Dr. Hugh Thatcher, treasurer, reported a \$70,000 deficit in the ISMA budget. The Board moved that the budgetary deficiency be referred to the Board Committee on Economic and Fiscal Affairs and that this committee prepare, if needed, a resolution for the House of Delegates.

Statistical information was presented to the Board by Dr. Steven C. Beering, Dean, Indiana University School of Medicine. Out of a total class of 305, he said there would be 286 Hoosiers starting their freshman year at medical school (preference is given to Indiana's young men and women). There were 812 applications from state students, with the grade average approximately 3.66. Over two-thirds of the students are receiving student aid. He pointed out that 60 percent of the I.U. graduates are staying in Indiana to practice and that this percentage is better than that achieved by any other state in the nation. Commenting on physician-to-population ratio, the Dean said the national average is 160 to 100,000 population. Indiana has a ratio of 105 to 100,000. And, with everything functioning as is projected, by 1982 Indiana would meet the current national average; however, by that time the national average will have also moved ahead.

In continuation of the discussion of health service area designations under P.L. 93-641, Dr. Arvine G. Popplewell, a member of the Board liaison committee on area designations, and Dr. William Paynter, state health commissioner, addressed the Board. Dr. Popplewell said he had pushed for five areas in the state but that Dr. Paynter had stressed the importance of a three-area designation, in that it would minimize the size of the overall state agencies, with only three areas reporting rather than five. Sufficient monies are available to each of three areas to do a fairly complete job and Dr. Paynter is committed to permit subregionalization, with three subregions in each of the major regions, and is also committed to the assurance of physician input of significant nature in both subregional and regional areas. Asked how the establishment of health-service area administrations would be accomplished, Dr. Paynter said that the Department of Health, Education, and Welfare would assume this activity. He said that the three-region organizational plan had been sent to HEW but presently there are no regulations, no system of Board selection, etc. He said he felt the ISMA should form a consortium of health care providers; i.e., the Dental Association, the Hospital Association, and others, who are concerned with the development of strategy and who would demonstrate an early interest in shaping the plan. HEW, he said, will accept applications from the providers who wish to lead in these regional formations.

In support of Dr. Lowell Steen's candidacy for AMA Trustee at the Atlantic City meeting, the Board approved \$3,000 in support and also authorized the delegation to utilize long distance calls to other delegations requesting support.

The Social Security Administration, Dr. Santare reported, offered to ISMA the option of collecting data on prevailing charges, physician fees and physician specialties. This participation by ISMA was rejected on motion of the Board.

The Board voted to adopt the substance of the policy statement of the Texas Medical Association concerning utilization review. Some of the points are:

- (1) The expense of conducting utilization review programs shall be borne by the company or agency which requires review. Physicians who work in a review capacity shall be appropriately compensated for their services.
- (2) Nonphysician professionals who work in a review capacity shall be responsible to and shall be directed by physicians.
- (3) The Association feels it will best serve the interest of the public, patients, and medical profession if physicians will lend their experience and expertise to the development and management of the system's design in-

to which medical statistical data will be fed.

The meeting adjourned to convene on June 8, 1975.

Gratitude was expressed to Dr. M. O. Scamahorn for his activity and involvement with Reference Committee F in studying the financial picture of the AMA and for the committee's recommendations for revitalizing the fiscal structure.

The Board instructed our delegation to the AMA to oppose all resolutions referring to mandatory relicensure and recertification.

The Board moved that an appropriate memorial plaque be presented at the annual convention of the ISMA to Mrs. K. O. Neumann, honoring the activity and dedication of Dr. Neumann to the Indiana State Medical Association.

The Indiana Academy of Physicians' Assistants request for a liaison representative from the ISMA Board was approved. President Wilhelmus named Dr. Franklin Bryan as the liaison representative.

The Board went on record opposing claims-made policies and at the same time approved a visitation of the president and representatives of his selection to make a personal call on the president of St. Paul Insurance Company to discuss the company's policy.

For presentation to the ISMA House of Delegates, the Board is to prepare a resolution requesting establishment of a medical examiners' system in Indiana.

Inconsistencies in ISMA-endorsed insurance programs were called to the attention of the Board. Two major medical programs (one through Blue Cross/Blue Shield, and one through CNA, and approved by the Board) are both being carried in some instances by members. The Board moved that the matter be referred to the Commission on Medical Economics and Insurance for review.

Dr. David Crane, chairman of the Commission on Public Information, proposed the utilization of radio spot announcements in conjunction with the Bicentennial celebration. These spots, he said, would be prepared by a member of the ISMA Speakers Bureau (a radio and TV professional announcer) and would contain a credit line to the ISMA. The Board moved this matter be tabled until the August meeting, at which time both this proposal and another medical tape program proposal made to the Marion County Medical Society could be reviewed.

Dr. Eli Goodman, chairman of the Board Committee on Economic and Fiscal Matters, summarized actions of the committee's meeting. The committee has recommended that a budget for next year be ready for the August meeting of the Board. He said the membership in all probability could expect a dues increase.

The meeting adjourned to convene on Aug. 10, 1975.

In conclusion, this has been a year full of major problems for medicine. We have, I believe, had a taste of success in some of our battles; for example, passage of a Medical Malpractice Act, a successful suit by AMA against utilization review regulations, and the passage of a new Medical Practice Act. We have also seen the election of multiple Hoosiers to AMA offices of importance, which will be of great help to ISMA.

We must, however, be careful that we are not lulled into complacency by these successes, because each area mentioned requires constant vigilance and continued work to assure ultimate success. We have, as well, other areas of immediate concern to medicine which must be addressed. One such area is PL 93-641, which demands immediate concern by physicians and appropriate action. Another area that I feel is and will continue to be of major concern is the area of data handling. I would hope that ISMA will approach this latter subject with a view to protecting our patients' right to privacy and, secondly, to protect ourselves against misuse or misapplication of stored health data.

It is easy to see that medicine is being bombarded almost daily by encroachments on the practice of medicine in a free enterprise system. These encroachments or attempts at encroachment are from every conceivable source and will necessitate a continuing, aggressive battle by organized medicine to protect our patients' freedoms and ours. We must therefore strengthen our organization and be willing to spend of our time and talents to afford such protection or we will soon be looking back with regret at freedoms lost without a fight.

It has been a pleasure, though no little work, to serve as chairman of the Board of Trustees of ISMA this past year. I wish my successor well and pledge support to him and to ISMA in the difficult times ahead.

RICHARD INGRAM, M.D.
Trustee

First Trustee District



BERNARD B.
ROSENBLATT, M.D.
Trustee

The First District Medical Society held its annual meeting on May 8, 1975, at the Rolling Hills Country Club, Evansville, with 120 persons present. Mead Johnson and Company hosted the social hour. The speaker for the evening,

the Rev. Tom Mullen, Associate Dean at Earlham College, Richmond, gave a very interesting and entertaining program.

Gilbert M. Wilhelmus, M.D., president of the Indiana State Medical Association, commented on the new professional liability insurance bill, another bill which proposed to permit foreign medical graduates to be licensed to practice medicine in Indiana after a two-year preceptorship without taking the examination required of American-trained physicians, and the new Medical Practices Act. He also reported on a meeting with the Indiana congressional delegation in Washington, D.C.

Dr. Rosenblatt then presented a report, and noted particularly that the new Medical Practices Act includes a definition of the terms "physician" and "practice of medicine" in such a way that these cannot be used by chiropractors or others who are not medical doctors. He remarked that a medical doctor must, under terms of the act, be a citizen of the United States or in the process of obtaining citizenship. A new board is also created which has broad powers to discipline physicians. Dr. Rosenblatt mentioned that the ISMA Board of Trustees during the past year has dealt with questions involving health planning, peer review and the usual problems of financing. He also pointed out that ISMA has a very active speaker's bureau which makes lay speakers available to talk in any part of the state on medicine and politics. Finally, Dr. Rosenblatt asked those at the meeting to stand in recognition of Dr. Wilhelmus for his outstanding and successful efforts to insure passage of legislation which would relieve the professional liability insurance problem. *It was officially moved that recognition of Dr. Wilhelmus be included in the minutes, and this action was duly recorded.*

Albert S. Ritz, M.D., First District president, called the attention of those present to the fact that it was the Vanderburgh County Medical Society Board of Directors which originally approved a resolution calling for a redefinition of the term "physician"; this resolution was forwarded to ISMA and adopted by them.

Ralph F. Carlson, M.D., First District trustee on the Board of Indiana Blue Shield, reported that all physicians in the state recently received a questionnaire asking their opinion of certain surgical procedures being carried out in medical offices. He remarked that early returns indicate there is much interest in this possibility and it may be that Blue Shield will review its reimbursement policy to see whether such procedures should be covered at less cost than is necessary when they are carried out in the hospital. Dr. Carlson introduced Mr. Gary Miller, Director of Provider Relations for Blue Shield. Also introduced were Ms. Beverly McGraw, Blue Shield Field Representa-

tive for the area, and Mr. Phil Sizelove, Senior Consultant for Blue Shield.

In its final action the membership elected Martin J. Bender, M.D., president of the First District for 1975-76, John H. Barrow, M.D. vice-president and Herman F. Rusche, M.D. secretary-treasurer.

BERNARD B. ROSENBLATT, M.D.,
Trustee

Second Trustee District



PAUL W. HOLTZMAN,
M.D.
Trustee

This has been a year of enlightenment, service, and reward.

We have been enlightened by the fact that doctors work together when their pocketbooks are threatened. We have been enlightened by the fact that we have in limbo vast young talents who can rise to an occasion with vigor, eagerness, and enthusiasm. We have been enlightened by the fact that, in spite of being in a profession which has lost some of its prestige by the actions of a few, we still have clout both as individual doctors and as an organization.

The service of the delegated few has been expanded to include interested doctors who now attend their respective society meetings and are anxious about the changing times. Time in service is still wanting, but many have contributed dollars to expand the cause. Here again, the youth of our organization have come forth with tremendous effort in service for the good of the Indiana State Medical Association.

Our rewards to date include, of course, the passage of House Bill 1460. But more importantly, our reward has been the restatement by the people of their confidence in the medical profession. Organized medicine is being revitalized.

I compliment all of those whose diligence and interest is reawakening our association to its importance.

Without fighters there can be no battle and without battles there can be no victories.

PAUL W. HOLTZMAN, M.D.,
Trustee

Third Trustee District



ELI GOODMAN, M.D.
Trustee

The 1974 Annual Meeting of the Third District Medical Society was a combined meeting with the Third District of the Indiana Academy of Family Practice.

The meeting was held Sept. 14-15 at the Marriott Resort Center, Clarksville.

President Claude J. Meyer, M.D., presided and was reelected to that office. Dr. Charles McCalla of Paoli was elected secretary to succeed Dr. Robert K. McKechnie.

Dr. Thomas Neathamer was reelected alternate trustee and Dr. John Paris was renominated to the Blue Shield Board of Trustees.

The scientific program was sponsored by Wyeth Company and was given by Dr. and Mrs. Edgar Stuntz of Purdue University.

A dinner dance on Saturday night was followed by a "Bloody Mary" brunch on Sunday morning. The state association was represented by a contingent including staff and headed by Board Chairman Vincent Santare.

Golf, swimming and water sports were available to all those who desired.

It was decided during a brief Sunday morning business meeting to hold the 1975 meeting at the same location, the Marriott Resort Center, Clarksville, Indiana, and the 1976 meeting at the Sheraton resort at French Lick.

ELI GOODMAN, M.D.
Trustee

Fourth Trustee District



HOWARD C.
JACKSON, M.D.
Trustee

The annual meeting of the Fourth District Medical Society was held at the Hillcrest Country Club, Batesville, June 4, 1975. Elections were held during the business meeting which began at 4:00 p.m. Dr. Robert Acher, Greensburg, was elected president, Dr. Ivan Lindgren of Aurora was elected vice-president, and Dr. Alvin Henry was re-elected our Board Member to Blue Shield.

The 1976 Fourth District Medical Society will be hosted by Decatur County at Greensburg on an as yet undetermined date. The afternoon scientific session was well organized, well presented and well received. President Wilhelmus spoke at the evening dinner regarding medical liability and the Patient's Compensation Act. We are indebted to Dr. Wilhelmus, the ad hoc Professional Liability Insurance Committee, and the Indiana Medical Foundation for their efforts in securing passage of this important landmark act. Dr. Everett Bickers, Floyd Knobs, alternate delegate to the AMA, was present at our evening

meeting and spoke regarding AMA matters.

Unfortunately, all we wished for was not granted by the 1975 Legislature. The next year may see many changes and, hopefully, answers to our questions about our Act and about its effect on availability of insurance, its structure, its cost, about our apparent, and about our eventual liability. We congratulate Dr. Wilhelmus, the committee, the Foundation and all the Indiana and Fourth District physicians who worked hard for the passage of this Act. It was truly a team effort.

Health Service Agencies took over where Professional Standards Review Organizations left off as our second most pressing concern. 1975 and 1976 will see many changes in how we adjust, adapt and organize in the face of yet another threat to the private practice of medicine. "Forbes" magazine in its July 15, 1975, issue, states: "The day of self-policing is probably past." "Forbes" quotes AMA executive vice-president Dr. James Sammons, "Of all the bills they've ever passed short of declaring war, this is the most dangerous. It vests decision making power in the hands of totally unprepared people." I would agree that this is the most dangerous bill but it seems all too evident to me that the health planners, local Comprehensive Health Planning executives, misguided physicians and anti-doctor lay people are all too prepared and eager to wield the decision making and regulatory power in the Health Planning and Resources Development Act of 1974—P.L. 93-641.

HOWARD C. JACKSON, M.D.,
Trustee

Fifth Trustee District



C. M. SCHAUWECKER,
M.D.
Trustee

The outstanding event of this past year, in my opinion, was the solidarity of the membership of the ISMA in their successful effort in getting professional liability insurance legislation passed. The leadership was magnificent. One cannot help but wonder just what might be accomplished on the national level if all physicians united behind the AMA and worked together just as hard for those causes we know to be just, and against those who would destroy the very principles that made American medicine the finest in the world. The idea is thought-provoking, isn't it?

The Fifth District held its annual meeting at the Holiday Inn at Terre Haute on May 14th. The business meet-

ing was exceptionally well attended, with Mr. Robert Amick representing the ISMA and Mr. Gary Miller representing Blue Cross. Two past presidents of the ISMA were also present: Dr. Joe Dukes of Dugger, and Dr. Malachi Topping, Terre Haute. The business meeting was conducted by President Paul Humphrey, Terre Haute, and there was considerable discussion concerning the recently passed malpractice act. It was also noted that several physicians had received notices of a marked increase in their malpractice insurance premiums, with no relationship to past or present litigation. Simply a blanket outlandish increase, and it is apparently statewide. Some expressed the view that ISMA should give considerable study to starting its own insurance company; others thought that the recently enacted law should be given a chance to work, and perhaps such a major step might not prove to be necessary.

The election of officers was held and the new officers for the Fifth District are as follows: Dr. Robert Oehler, Brazil, was elected president; Dr. Nancy Oehler, Brazil, was elected secretary-treasurer. The meeting next year will be held at Brazil.

Also elected was Dr. Edward Johnson, Terre Haute, to fill the unexpired term of Dr. Fred Dierdorf, Terre Haute, as Blue Cross representative. Dr. Dierdorf is moving to Florida. Also, Dr. Cleon Schauwecker, Greencastle, was reelected trustee of the Fifth District.

After the dinner, Mr. Temple Spencer gave a very thought-provoking talk concerning the good and bad sides of the medical profession, as well as the country as a whole. The talk was very well received.

C. M. SCHAUWECKER, M.D.,
Trustee

Sixth Trustee District



PAUL M. INLOW, M.D.
Trustee

I will not be the only Trustee to make the observation that when physicians have a common goal and stand united we can initiate change to improve the practice of medicine. I urge the physicians of the Sixth District and state to become active and stay active in their support of ISMA.

The Sixth District meeting was held at Richmond on May 15th, when we had the opportunity to tour the new facilities at Reid Memorial Hospital. The afternoon speaker was William Murray, M.D., Indiana Director of Mental Health, whose topic was "The Current Status of

State Hospitals and Comprehensive Mental Health Centers."

Our state president, Dr. Wilhelmus, was a very welcome guest. He gave an update on Bill #1460 as passed, and his feelings and advice on how this legislation will affect our practice.

The president of the Sixth District, Dr. Davis Ellis, presided at the business meeting. Dr. Glen Ward Lee was reelected alternate trustee. The new officers are Dr. William Kerigan, President, Dr. C. G. Clarkson, Vice President; and the Secretary-Treasurer is to be elected by the Henry County Medical Society.

The dinner was held at Forest Hills Country Club. Our speaker was Joseph Cloud, the director of the Indiana Department of Natural Resources. He talked about and showed slides of the state parks, recreational facilities, forests, reservoirs and wildlife preserves.

P. M. INLOW, M.D.,
Trustee

Seventh Trustee District



JOSEPH F. FERRARA,
M.D.
Trustee

IN UNITY THERE IS STRENGTH

In the minutes of the June ISMA Executive Committee Meeting special note was taken of the decline in the membership in ISMA and AMA.

To those who stand on sidelines and do not give of themselves, do not give service, do not participate, do not attend important meetings but just sit on the sidelines and gripe, find fault and say "Why don't they do this or that?" my suggestion is: Participate, get active, join the effort rather than resign, and correct deficiencies you complain of—if there are any.

Decisions will have to be made with or without you. By participating, one has the voice, can be heard, and one might be surprised that "little you" influenced the course of events.

In the ISMA and down through the county societies, no officer receives any salary. There may be remunerations that do not cover actual expense, but that is all.

Unless one has medical political aspirations there is no future in the offices—no recompense except for a sense of gratification from contributing, participating and correcting or finding solutions to some of the problems affecting the practice of medicine.

ISMA has achieved considerably in the past year and deserves the support and participation of the individual members of the medical profession.

Just recently the ISMA reminded me of a family with its infighting but against an "outsider" the members united. For example, in the tough decision whether to oppose claims-made insurance and, in so doing, knowing that some members would be hurt, one factor that influenced the final decision was that many of the ISMA membership volunteered to make contributions, pay higher dues, pay higher premiums, or help in any way to help their fellow practitioners who might be hurt by the decision to oppose claims-made insurance. This made the heavy burden of making an important and crucial decision a little more bearable.

House Bill 1460, though not perfect by any means, was a great achievement and a good example of the medical profession unifying for a common cause.

One suggestion to stimulate, create interest, and participation of the membership is that the ISMA Board and House of Delegates should make some restriction on the number of high offices one individual can hold at any one time. There is not one of us who is indispensable, not one of us has all the brains, so why not spread the offices to deserving members, thus spreading participation and possibly inducing more interested competent individuals to take active part in ISMA functions and determine its policies.

In creating interest we stimulate participation. Through participation we might stimulate unity and in unity there is strength—the strength needed to overcome some of the obstacles facing the medical profession. So, let's all pitch in and help.

JOSEPH F. FERRARA, M.D.,
Trustee

Ninth Trustee District



WILLIAM M.
SHOLTY, M.D.
Trustee

This year has been one of great activity and accomplishment for the Board of Trustees and the ISMA as a whole. We all can take pride in the Indiana legislature passing the new Medical Practice Act and the Patient's Compensation Act. Indiana was a pioneer in patients compensation field of legislation. We feel that these acts will solve many of medicine's problems.

Just when we thought that everything was all set and no great problems were pending, the St. Paul Fire and Marine Insurance Company insisted on issuing only a claims-made type of malpractice policy. The Board of Trustees, after careful deliberation, numerous meetings and

telephone conferences, unanimously recommended to the state insurance commissioner that he not sanction the claims-made type in Indiana.

The 9th District Meeting was held at the Curtis Creek Country Club in Rensselaer on June 12. The Jasper and Newton Medical Societies were host. Dr. Arthur Schoonveld presided. Dr. Kenneth Ahler was secretary-treasurer. ISMA President-elect Dr. Vincent Santare gave a report on the medical malpractice situation. Dr. Peter Petrich introduced Judy Griffin and Bill Sizemore, Blue Shield field representatives. He then reported on Blue Shield procedures and the AMA delegation activities.

Dr. Max Hoffman reported on the 1975 ISMA Convention Planning Commission. Reports of the work of various commissions were given by Drs. John Knote, Kenneth Ahler, William Ferguson, Bruce Work and Robert Vermilya. The Trustee in this report discussed the need for physician assistant legislation. This portion was removed from the Medical Practice Act.

He also reported on the great use of the Tel-Med tapes and his frustration in trying to raise funds for its support. A resolution was passed recommending a \$25 increase in ISMA dues specifically to support the Tel-Med program.

The Trustee also reported on the progress of the Indiana Medical Museum and a resolution was passed for ISMA to provide \$2.50 per ISMA member per year for support of this project.

The program, following a fine well-attended banquet, was an address given by Governor Otis Bowen. Next year's meeting location was discussed. The location is to be worked out by the Trustee, field representative and the host county, which is to be Tipton County.

WILLIAM M. SHOLTY, M.D.,
Trustee

Tenth Trustee District



MARTIN J. O'NEILL, M.D.
Trustee

Officers elected at the last annual meeting of the Tenth Trustee District, held Sept. 24, 1974, at Valparaiso Country Club were Dr. J. M. Sierkierski, Griffith, president; Dr. J. R. Brown, Valparaiso, secretary-treasurer; Dr. M. J. O'Neill, Valparaiso, trustee, and Dr. Leonard W. Neal, Munster, alternate trustee. The meeting was conducted by Dr. Mario Mansueto, outgoing president, and Dr. Vincent J. Santare, outgoing trustee. There was a golf tournament

with prizes awarded to the winners, and a guest speaker, Dr. George W. Crane, who spoke at the ladies' meeting in the afternoon and again at the dinner meeting.

Dr. Santare reported on State Association activities, covering the 1974 House of Delegates meeting. State Association effort to organize a group malpractice program, PSRO, including I-Medic Program, Tel-Med, ISMA headquarters staff shortages, and the existing inadequate dues structure in the State Association.

Guests present were Dr. Peter Petrich, Dr. Malcolm Scamahorn, both past presidents of ISMA, Mr. Stan Tope of Indiana Blue Shield, Blue Shield board members, Dr. Peter Gutierrez and Dr. William Fitzpatrick, and Foundation Executive Secretary Charles Shoemaker.

Officers serving the Lake County Medical Society this year are Dr. Walfred (Chuck) Nelson, president; Dr. David Ross, Gary, vice-president, and Dr. Thomas Gehring, Merrillville, secretary.

In Porter County Dr. Leon Armalavage is president and Dr. Frank Sturdevant is secretary. Both are of Valparaiso.

The outstanding event in the Tenth District this year was the election of Dr. Vincent Santare, Munster, president-elect of the ISMA, at the 125th annual convention in October 1974. Dr. Santare has represented the Tenth District as chairman of the Board of Trustees during the 1973-74 term.

Second to this, of course, was the election of Dr. Lowell Steen, Whiting, former ISMA President, to the Board of Trustees of the American Medical Association in June 1975.

The Calumet Foundation for Medical Care has been active during the year and has established a well developed peer review program. Having been given a planning grant for PSRO activity, the Foundation has developed a new organization, CAPRO (Calumet Area Professional Review Organization) that encompasses Lake, Porter and LaPorte counties, with membership of approximately 71% of the doctors in this area and is getting closer to its goal of becoming a Conditional PSRO in Indiana Area I.

Members of both Lake and Porter County Medical Societies were very active during the campaign for medical liability legislation and contributed a great amount of time and money in the successful attempt to get legislation passed. The members are grateful to the legislators of the area and are inviting them and their wives to the next annual meeting of the Tenth District in September 1975. There was good support, also, for the Medical Practice Act.

There have been several meetings concerning the National Health Planning and Resources Development Act of 1974.

There was disapproval by both counties of the decision to divide the state into three geographic areas and the reasons for disapproval are very legitimate. An effort is being made to cooperate with the other counties across the north part of the state in developing an organization to implement this law.

Porter County continues its Charitable Trust Program and has received recognition for this meritorious service from other counties and states.

The next annual meeting will be held Sept. 24, 1975, at the Valparaiso Country Club. An alternate trustee and a Blue Shield board member will be elected at this time.

MARTIN J. O'NEILL, M.D.,
Trustee

Eleventh Trustee District



JAMES A. HARSHMAN, M.D.
Trustee

Since last October the physicians of the state and the ISMA, through its officers and Board of Trustees, have been confronted with the most severe problem that the profession has ever faced, professional liability insurance. Through the united effort of all physicians remedial legislation was enacted by the Indiana General Assembly. Although its test of constitutionality is yet to come, we have every reason to believe the bill will withstand the test. Even though H.B. 1460 was not a perfect piece of legislation, it did correct many of the inequities that existed under the old statutes. Further amendments might be necessary. All physicians are deeply grateful to our president, Dr. Wilhelmus; to Dr. Bill Cast and Dr. Paul Muller; to our legal counsel, Mr. James Stuart, Mr. Dick Guthrie, and Mr. Fred Garver, and to our own association administrative staff for their accomplishment.

While the fires still rage on the front burner, smaller flames have broken out on the back burner at the federal level. The AMA has taken the federal government to court for the first time in its history and has won a temporary injunction on the implementation of the UR regulations. Public Law 93-641, the National Health Planning and Resources Development Act of 1974, has been enacted by Congress. This bill has far reaching implications and establishes "mini-HEWs" in each state. Three are proposed for Indiana. In June 1975 the AMA House of Delegates instructed the AMA Board of Trustees to take any action, including legal action, they deem appropriate and effective to prevent the implementation of PL 93-641.

Other organizations are frustrated by attempts of the federal government to control the health care delivery system and are seeking relief from these actions by bringing suit against HEW. The Association of American Medical Colleges filed a suit which asked that the revised schedule of limits on hospital inpatient routine service costs be declared illegal and invalid. AHA has filed suit to stop the federal government from eliminating the 8.5% Medicare nursing cost differential given to offset the extra cost of aged patient care. The JCAH filed suit for a permanent injunction barring HEW from further public disclosure of JCAH survey documents.

In the past, organized medicine's efforts in Washington were totally directed at lobbying. It is clearly apparent that much of our effort must also be directed at seeking legal redress in court to protect the best interests of our patients and their physicians.

In order that we as an association can respond quickly to the issues that face us, a reorganization of our committee and commission structure is imperative. The machinery of yesteryear needs redesigning to handle the problems of the 70s. If ISMA is to survive and represent the practicing physicians in years to come, "corrective surgery" will be needed. It can not come too soon. Lost motion on the trivia will have to be eliminated in order that we may concentrate our efforts on the major issues that face us. Priorities and goals must be established. Our leadership must foresee problems before they become crises, in order that solutions and their alternatives can be worked out.

Last September, Cass County was the host for the 11th District Medical Society in Logansport. The meeting was well attended. Mr. Stanton Evans was guest speaker. Dr. George Wagoner of Delphi was elected president and Dr. Fred Poehler of LaFontaine was reelected secretary of the District Society. Dr. Lloyd Hill of Peru was reelected alternate trustee, and Dr. Don Wagoner of Burlington was elected to the Board of Directors of Blue Shield. The next district meeting will be held on Sept. 17, 1975 in Delphi. Carroll County will be host.

JAMES A. HARSHMAN, M.D.,
Trustee

Twelfth Trustee District



ALVIN J. HALEY, M.D.
Trustee

This year's 12th District officers were: President, Robert Edwards, M.D.; vice-

president, Karl Schlademan, M.D.; secretary-treasurer, Tom Felger, M.D.; alternate trustee, Franklin A. Bryan, M.D.; Blue Shield representative, Kenneth Isenogle, M.D.; Blue Shield board member, Maurice Glock, M.D. I, Alvin J. Haley, M.D., am your trustee.

Our annual meeting was held Sept. 11 at the Fort Wayne Ramada Inn and featured a business meeting with reports and discussions. Wives were entertained by Nedra Feeley, doctors and wives were enlightedly entertained and informed about the energy crisis by Professor Hans Heinrich of Heidelberg College (Germany) and the Argonne National Laboratories.

Malpractice insurance was the issue claiming most of the ISMA's attention this year. Much of our time, money and energy went into the effort which culminated in a bill passed by our state legislature to become a standard for other states to emulate.

Great as our efforts were and fortunate as the outcome was with the Patient's Compensation Act, the malpractice problem will not go away. Malpractice premiums still escalate, St. Paul refuses to offer "occurrence" insurance, the Act is headed for constitutional testing in court.

The ISMA is currently considering offering a CNA malpractice coverage for its members.

Farsightedly, the Patient's Compensation Act creates a continuing commission to wrestle with the problem.

Other old and new national problems seem to be at this stage presently:

1. Utilization review regulations are temporarily (perhaps permanently!) stalled by the AMA's court action.
2. Court action to declare PSRO unconstitutional failed but it is languishing because of short funding.
3. The AMA is taking court action against MAC (Maximum Allowable Cost) drug regulations.
4. The AMA seems to be revitalizing itself but needs a whopping dues increase to regain financial stability.
5. The ISMA is considering the Blue Cross-Blue Shield Individual Practice Association concept (sort of a floating HMO).

The ISMA 12th District has introduced resolutions on the following subjects:

1. Calling for equal opportunities for all ISMA members regardless of race, color, or creed.
2. Opposing PSRO and prohibiting cooperation with PSRO.
3. Opposing PSRO but allowing cooperation because "it is the law of the land."
4. Granting Larry Pickering, executive director of the Fort Wayne Medical Society, honorary membership in the ISMA.
5. Calling on the State Board of

Health to allow more local latitude to meet health care needs—despite the bureaucracy of the health planning councils and the health service agencies.

6. Various resolutions calling upon third parties to offer better patient and physician services while interfering less with the patient-physician relationship.

During the year I have found the ISMA Board of Trustees individually and collectively diligent and intelligent, agonizing over its decisions because occasionally a few members had to be hurt to help the vast majority of members. Primary attention was given to helping our members deliver the best possible health care to all Hoosiers. Views so divergent as to encompass the entire membership were painstakingly hammered into a consensus.

The other trustees and I are looking forward to another year of facing, enumerating and prioritizing your problems, proposing and evaluating solutions, and judging which solution has the best prospect for succeeding.

ALVIN J. HALEY, M.D.
Trustee

Thirteenth Trustee District



G. BEACH GATTMAN, M.D.
Trustee

The 13th District Medical Society held its annual meeting at Elkhart on Sept. 12, 1974, at the Elcona Country Club. The annual golf tournament and tennis tournament preceded the business meeting. The business meeting was conducted by Dr. Jack Hannah, Elkhart. For the last two years, we have had an increase in attendance at our business meeting which, I hope, reflects an increased awareness and concern by our members in the affairs of our district and the ISMA. Along with the usual district reports, the commission members gave reports on their activities. The trustee report highlighted the actions of the Board of Trustees for the year 1973-74.

Election was held. Dr. John Hildenbrand, Jr., South Bend, was elected president, Dr. John Luce, Michigan City, president-elect, Dr. David Spalding, Mishawaka, secretary-treasurer, and Dr. G. Beach Gattman was reelected trustee of the 13th District.

Following the business meeting, a discussion on insurance was presented and some of the problems on malpractice insurance were aired. A number of guests were present, including Governor Otis R. Bowen, Dr. Bowen's wife Beth, Dr. Joseph Dukes, Dr. Vincent Santare, Mr. James Waggener, Mr. Howard Grindstaff, and Mr. Herb Dixon of Blue

Shield. The business meeting was followed by a banquet which was quite a lively affair with strolling musicians and artists painting a picture of a scene upside down. Following the banquet a play was presented. A good time was had by all.

G. BEACH GATTMAN, M.D.,
Trustee

Editor of THE JOURNAL

THE JOURNAL budget for this year was predicated on an increase in printing costs, postage and a necessary adjustment of salaries. The cost of paper, ink and printers' wages controls the printing bill. Inflation of the cost of living controls the salaries and affects postage rates.

The budget estimate for printing this year was \$10,000 above that for 1974. The budget figure for personnel was about \$4,300 above 1974. The average cost of mailing one copy of our journal has risen 37% in the past two years. Other expense items varied between the two years, some plus, some minus, to almost balance each other. Art work was budgeted for \$1,000 less this year. These changes amounted to about \$14,000, to raise the predicted expenses from \$86,000 in 1974 to \$100,000 in 1975.

The income expected for this year was almost the same as for 1974. The allocation from dues was listed as an increase, as was the income from local advertising, journal reprints, senior member subscriptions and sale of Rosters and Yearbooks. National advertising revenue was expected to be down, as compared to 1974, by a few thousand dollars.

Expected receipts for both years was in the neighborhood of \$59,000. The deficit for 1974 was forecast as some \$27,000, actually came to \$29,000. The forecast for this year was a deficit of about \$42,000. At the time this report is written the estimate of this year's deficit is about \$45,000. This differs from the forecast principally because the printing bill exceeded the estimate by \$3,500 and the revenue has been down by \$2,000. All figures in this report are rounded.

The supply of good scientific articles has been adequate. In fact, when the smaller issues are considered, our supply of articles has become too large. The "Seminars from Riley Children's Hospital" series, which was organized and nurtured by Dr. Joseph Fitzgerald with a view of a short article almost monthly, has, by necessity, been curtailed.

In addition to the usual special issues on cardiology and Roster, the January issue was devoted to malpractice. The "Electrocardiogram of the Month" has been reinstated under the direction of Dr. John C. Bailey. Dr. William F. Dugan, Jr., contributes the "Cancer Corner" each month. The May issue

highlighted the Wells County Medical Society Fall Conference of 1974 which was presented especially to honor Dr. Harold D. Caylor and Dr. Truman E. Caylor.

Plans are being made to reduce the size of THE JOURNAL still further to lessen the difference between income and outgo.

FRANK B. RAMSEY, M.D.
Editor

Delegates to AMA

The Indiana delegation to the American Medical Association successfully placed two men in top posts during the 124th Annual Convention of the AMA in Atlantic City, June 15 through 19, 1975.

Lowell H. Steen, M.D., Hammond, was elected to the office of trustee, and Patrick J.V. Corcoran, M.D., Evansville, was elected a member of the AMA Council on Medical Education.

The delegation participated in the review and study of more than 150 resolutions and reports during the five-day meeting and caucused two and three times a day to go over these reports and plan actions on the floor of the House.

Max H. Parrott, M.D., Portland, Ore., was installed as the AMA's 130th president. Richard E. Palmer, M.D., Alexandria, Va., was named president-elect, and George W. Slagle, M.D., Battle Creek, Mich., was elected vice president. Re-elected by acclamation were Tom E. Nesbitt, M.D., Nashville, Tenn., as speaker of the House, and William Y. Rial, M.D., Swarthmore, Pa., vice-speaker.

The House of Delegates voted to raise dues to \$250 annually for regular members and to \$35 for interns and residents, effective January 1, 1976. Dues for medical student members will remain at \$15. The dues increase is designed to bring the AMA's liquidity reserves to \$27,200,000 in 1977. It will enable the AMA to continue activities at the present dollar level while restoring some programs and initiating new activities to the extent of \$2 million a year for the next few years. The House also urged state, county and specialty societies to conduct a campaign to achieve 100% participation in the \$60 special assessment that was voted by the House at the 1974 Clinical Convention.

In its deliberations on the financial situation, the House worked with reports from its Special Committee, formed at the 1974 Clinical, and with background and statistical reports from the Board of Trustees and the auditors. Dr. Malcolm O. Scamahorn, Pittsboro, served on the Special Committee.

A number of fiscal recommendations made by the Special Committee of the House were adopted, including the appointment of an ad hoc committee on in-

ternal affairs to maintain liaison between the House and the Board and to report at the 1975 Clinical Convention. The House also reaffirmed a financial policy of a balanced budget with adequate reserves, recommended presentation of accounting and program budgets in simplified formats, and recommended an annual review and report by the Board on the dues level necessary to support the Association's activities.

The House endorsed the concept of restructuring the AMA and adopted the Special Committee's recommendation that the Council on Long Range Planning and Development prepare a plan to implement structural and operational changes. The report will be submitted at the 1975 Clinical. The House voted to continue on an inactive status the councils and committees proposed for discontinuance last fall, with the members to be used as ad hoc consultants as determined by the Board pending the report of the Council. It also voted that no other changes in the permanent council and committee structure be made pending the report.

The House gave full discussion to AMA publications and recommended to the Board that *JAMA* and *American Medical News* receive resources to keep them at the highest levels and that *Prism* be discontinued. The House authorized the Board to place all publications except *JAMA* and *AM News* on a subscription basis for members. It amended the by-laws to remove *Today's Health* as a membership benefit. The House recommended that subscription rates for the specialty journals be designed to make the publications self-supporting and that the number of issues of any AMA publication be reduced as an economy measure if necessary. It endorsed a policy of aggressive advertising promotion and asked the Board to implement the policy as soon as possible.

A Board report on progress toward establishment of an AMA professional liability reinsurance facility was received favorably by the House. It voted to form the reinsurance company and make it operational as soon as possible. The facility would require the participation of five state society captive companies with a minimum of \$12 million in annual premiums and AMA capitalization of \$1.5 million. The House also suggested that state societies consider using voluntary arbitration in conjunction with the American Arbitration Association and the American Hospital Association, or other mechanisms consistent with state laws, for proposed professional liability insurance legislation.

The House commended the Board for its "forthright action" in securing a preliminary injunction blocking implementation of HEW's utilization review regulations. It supported further action to protect the constitutional rights of

patients and physicians and urged physicians, through their hospital medical staff committees, "to continue to perform peer review directed at increasing the quality of patient care and reducing its cost." The House voted support of the Board in action, including legal action, to prevent the implementation of the National Health Planning and Resources Development Act of 1974. It also voted support to the Board "in continuing to pursue every possible action" opposing some provisions of the manpower bills and in its commitment "to pursue every avenue of legitimate persuasion and available legal action" on the regulations limiting reimbursement of physicians' fees under Medicare.

In his inaugural address, President Max H. Parrott, M.D., said continued quality of care is the basic picture that must emerge from "today's picture puzzle of medical and health-care issues." In light of government regulation of medical care, Dr. Parrott cited the need for a strong

AMA to preserve the quality of care. To give the AMA the capacity for effective action, he recommended that the offices of AMA vice president, president, president-elect, and immediate past president be abolished, that the speaker and vice speaker of the House of Delegates be given votes on the Board of Trustees, and that the chairman of the Board be elected directly by the House after nomination by the Board. "Hence," Dr. Parrott said, "the chief leaders and chief spokesmen of the AMA would be the Board chairman, acting for the elected officers and the House, and the executive vice president, acting for staff."

"Future Shock" has hit the AMA, said Malcolm C. Todd, M.D., immediate past president of the AMA, in his address at the opening session of the AMA's House of Delegates. The greatest shock waves, Dr. Todd said, are coming from the professional liability issue, but he emphasized that other areas, including clinical medicine, socioeconomics, na-

tional politics and the future, also demand AMA attention. Dr. Todd reiterated his suggestion for a university without walls for continuing education, to "lend a new image and a new prestige to continuing education." He urged the AMA to play a major role in the implementation of a new study, similar to the Flexner study, to determine whether the educational process is meeting the need for appropriate training of physicians.

PATRICK J. V. CORCORAN, M.D.
 LOWELL H. STEEN, M.D.
 JAMES A. HARSHMAN, M.D.
 JOHN O. BUTLER, M.D.
 MALCOLM O. SCAMAHORN, M.D.
Delegates

THOMAS C. TYRRELL, M.D.
 PETER R. PETRICH, M.D.
 GEORGE T. LUKEMEYER, M.D.
 ROSS L. EGGER, M.D.
 EVERETT E. BICKERS, M.D.
Alternates

Reports of Committees

Executive Committee

The Executive Committee met immediately following the organizational meeting of the Board of Trustees on Oct. 8, 1974, for the purpose of organizing the committee. By secret ballot, Dr. Donald M. Kerr was elected chairman. The other routine matters of business were dispensed with and, there being no further business, the committee adjourned to meet again on Nov. 23, 1974.

The meetings of the Executive Committee were held prior to the meeting of the Board of Trustees. Inasmuch as the minutes of the Executive Committee meetings have been published in THE JOURNAL and copies of the minutes are in the hands of the Reference Committee, we will not attempt to review the many transactions handled by this committee.

Unfortunately, Dr. Donald M. Kerr found it necessary to resign as chairman of the Executive Committee in August of this year and the Board of Trustees at its meeting on August 10 filled the vacancy by electing Dr. Eli Goodman of Charlestown to fill the unexpired term of Dr. Kerr. Immediately following the Board meeting, the Executive Committee met again for the purpose of organizing, at which time Dr. Hugh K. Thatcher, Jr., was elected chairman of the committee.

If you have followed the minutes of the Executive Committee in THE JOURNAL, or if you care to review with the Reference Committee, you will find this has been a busy year.

The Journal

Listed below is a comparative report of *The Journal* operations over the past several years and the first six months of 1975, as follows:

The first table shows the number of journal pages for the past six years (includes inserts).

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. No. Pages Per Issue
1969	1041	67	509	33	1550	129
1970	1131	74	403	26	1534	128
1971	970	70	426	30	1396	116
1972	933	69	433	31	1366	113
1973	877	73	321	27	1198	100
1974	870	69	282	31	1176	98

The table below shows the total printing costs of *The Journal*:

Year	Total Printing Costs	No. of Pages (Inserts Excluded)
1970	\$44,520.84	1346
1971	40,542.21	1232
1972	41,789.70	1106
1973	42,642.43	1028
1974	50,895.65	1176
1975 (6 mos.)	29,115.42	571

A comparison of advertising revenues for the first six months of the last four years, with a like figure for 1975, is as follows:

Year (Jan-June)	Sold by State Medical Journal Adv. Bureau	Sold direct By Journal	Total
1971	\$13,128.30	\$1,821.89	\$14,950.19
1972	17,869.96	1,622.60	19,492.56
1973	10,938.94	2,134.95	13,073.89
1974	10,280.92	3,151.00	13,431.92
1975	9,250.86	3,763.16	13,014.02

Membership Report

Total Members	December 1973	December 1974
ISMA	4,698	4,823
AMA	4,348	4,483
	July 31, 1974	June 30, 1975
ISMA	4,743	4,689
AMA	4,416	4,167

DISTRICT REPORT AS OF JUNE 30, 1975

	+ Gain	- Loss
DISTRICT	ISMA	AMA
1	- 4	- 6
2	-11	- 18
3	+ 2	- 17
4	+10	+ 6
5	- 5	- 17
6	—	- 6
7	-27	-107
8	+ 5	- 17
9	—	- 21
10	- 1	+ 1
11	- 2	- 8
12	- 7	- 19
13	-14	- 20
	-54	-249

DEATHS

December, 1974	58
As of June 30, 1975	31

County-District Membership Report

	Dec. 31, 1974 ISMA	July 31, 1974 ISMA	June 30, 1975 ISMA	June 30, 1975 AMA
1st DISTRICT				
Gibson	13	13	13	13
Perry	7	7	7	7
Pike	2	2	2	2
Posey	6	6	6	6
Spencer	4	4	4	4
Vanderburgh	280	279	276	256
Warrick	6	6	5	4
TOTAL	318	317	313	292

2nd DISTRICT				
Daviess-Martin	20	20	17	14
Greene	16	16	15	11
Knox	44	44	45	42
Owen-Monroe	102	102	93	67
Sullivan	16	15	16	14
TOTAL	198	197	186	148

3rd DISTRICT				
Clark	55	55	55	37
Du Bois	25	24	28	25
Floyd	44	44	47	38
Harrison-Crawford	9	9	9	9
Lawrence	42	41	35	23
Orange	6	6	7	6
Scott	8	8	8	8
Washington	8	8	8	7
TOTAL	197	195	197	153

4th DISTRICT				
Bartholomew-Brown	70	69	74	64
Dearborn-Ohio	16	15	15	13
Decatur	8	8	11	10
Jackson	*23	*20	18	15
Jefferson-Switzerland	29	27	27	23
Jennings	—	—	7	7
Ripley	11	11	8	7
Total	157	150	160	139
*Jackson-Jennings in 1974				

5th DISTRICT				
Clay	15	14	12	11
Parke-Vermillion	14	14	14	13
Putnam	18	18	17	17
Vigo	119	119	117	102
TOTAL	166	165	160	143

6th DISTRICT				
Fayette-				
Franklin	18	18	18	17
Hancock	26	26	25	21
Henry	38	38	36	32
Rush	12	12	12	12
Shelby	22	22	20	16
Wayne-Union	76	74	79	74
TOTAL	192	190	190	172

7th DISTRICT				
Hendricks	26	26	27	20
Johnson	35	35	35	24
Marion	1178	1129	1104	1032
Morgan	24	23	20	16
TOTAL	1263	1213	1186	1092

8th DISTRICT				
Delaware-				
Blackford	131	131	135	100
Jay	14	14	13	12
Madison	100	97	99	63
Randolph	18	18	18	12
TOTAL	263	260	265	187

9th DISTRICT				
Benton	7	7	6	4
Boone	18	18	17	14
Clinton	13	13	12	10
Fountain-				
Warren	11	11	11	9
Hamilton	19	18	14	11
Jasper	9	9	8	8
Montgomery	25	25	26	21
Newton	4	4	4	3
Tippecanoe	158	157	166	139
Tipton	12	12	10	9
White	8	8	8	8
TOTAL	284	282	282	236

10th DISTRICT				
Lake	476	475	474	437
Porter	79	77	77	74
TOTAL	555	552	551	511

11th DISTRICT				
Carroll	8	8	9	9
Cass	32	31	27	23
Grant	82	82	81	80
Howard	71	71	73	67
Huntington	18	18	22	17
Miami	13	13	14	14
Wabash	27	27	22	16
TOTAL	251	250	248	226

12th DISTRICT				
Adams	13	13	12	11
Allen	328	327	324	287
De Kalb	19	19	18	15
La Grange	9	9	8	6
Noble	16	16	16	15
Steuben	13	13	12	12
Wells	51	51	51	50
Whitley	13	13	13	13
TOTAL	462	461	454	409

13th DISTRICT				
Elkhart	118	118	109	96
Fulton	7	7	7	6
Kosciusko	18	18	19	13
La Porte	96	94	89	76
Marshall	20	19	21	19
Pulaski	4	4	3	3
St. Joseph	246	243	240	238
Starke	8	8	9	8
TOTAL	517	511	497	459

1st District	318	317	313	292
2nd District	198	197	186	148
3rd District	197	195	197	153
4th District	157	150	160	139
5th District	166	165	160	143
6th District	192	190	190	172
7th District	1263	1213	1186	1092
8th District	263	260	265	187
9th District	284	282	282	236
10th District	555	552	551	511
11th District	251	250	248	226
12th District	462	461	454	409
13th District	517	511	497	459
TOTAL	4823	4743	4,689	4,167

Hugh K. Thatcher, Jr., M.D. *Chairman*
 Gilbert M. Wilhelmus, M.D.
 Joe Dukes, M.D.
 Vincent J. Santare, M.D.
 William R. Clark, M.D.
 Eli Goodman, M.D.
 Donald M. Kerr, M.D., *Chairman,*
resigned

Grievance

The Grievance Committee has not met during the past year, inasmuch as under the actions taken by the House of Delegates it has been the policy of the committee to refer complaints to the physician in hope that he and the patient might resolve their differences and then, if this is not successful, the complaint is referred to the county medical society grievance committee; the state committee now functions only when the county society requests that the state committee take charge. This has been the policy during the past year. The state committee has received five complaints and all have been resolved either between the physician and his patient or the county medical society involved and the physician and his patient.

RICHARD S. BLOOMER, M.D.,
Chairman
 WILLIAM D. PROVINCE, M.D.
 EUGENE S. RIFNER, M.D.
 KENNETH WILHELMUS, M.D.
 HARRY L. CRAIG, M.D.
 THOMAS C. TYRRELL, M.D.
 LAWRENCE K. MUSSELMAN, M.D.
 GENE MOORE, M.D.

Medical-Legal Review

This year the Medical-Legal Review Committee dealt with a minimum num-

ber of problems and "sat in the wings" watching with interest the activities of the President and his Ad Hoc Committee working for passage of H.B. 1460. Many of the areas which the committee had considered in the past years involved the dramatic increase of medical liability suits. Our attempt to initiate a binding arbitration system at the Indiana University Medical Center with the help of Chancellor Glenn W. Irwin, Jr., and Dean Steven C. Beering met with failure because of our inability to locate an insurance company willing to cover this group.

At a meeting held January 22, 1975, the problem of unwillingness on the part of some doctors to appear in court to testify for their patients involved in personal injury cases was discussed. This situation was demonstrated to the legal members of our committee by way of a letter of complaint against one of our members, alleging this type of practice. This matter will be considered at the fall meeting of the committee.

There were no court or administrative actions during the past year which needed action relative to Article III, Section 3 of the Interprofessional Code adopted by the Indiana State Medical Association and the Indiana State Bar Association. It is hoped that the proposed change in the Constitution and Bylaws, recommended by the Medical-Legal Review Committee and approved last year by the Board of Trustees, concerning the right of the ISMA to hire an attorney of competence in the medical-legal field to aid physician-members, will be implemented at the House of Delegates in October. This attorney would serve as consultant to a physician's own attorney and hopefully provide added competence and experience.

Our Association has been indeed fortunate to have participated in the enactment of the nation's number one "malpractice legislation," and our committee will wait and watch with eagerness as the ever-increasing number of claims are tested with this new law. There seems little doubt that the frequency of lawsuits against doctors will increase, but hopefully the panel will function as intended and, contrary to the opinion of the insurance companies, will eliminate the "nuisance" lawsuits which have no factual basis.

Our hats are off to President Gilbert Wilhelmus for his perseverance and leadership and to all those others involved in achieving the passage of H.B. 1460. Time will tell if this legislation will give our members the relief we most certainly require!

JOHN W. BEELER, M.D.
Chairman
 JOSEPH G. S. WEBER, M.D.
 ROBERT R. KOPECKY, M.D.
 GEOFFREY SEGAR
 JAMES J. STEWART
 WILLIAM HALL
 JOHN O'CONNOR

Sports and Medicine

The Committee on Sports and Medicine in 1974-1975 continued to provide liaison between Indiana State Medical Association and especially the Indiana State High School Athletic Association. This committee helped solve many medical problems through this communication at local levels. The committee provided monthly articles in the bulletin of the Indiana State High School Athletic Association pertaining to medicine and athletics for the dissemination of knowledge to high school coaches, teachers and administrators.

The main projects, however, in 1974-75 of our committee are twofold. One was the preparation, organization and presentation of a sports symposium for the annual meeting of the Indiana State Medical Association in French Lick on Oct. 21, 1975. This program will deal with the medical and psychological problems encountered in athletics. The outline of this program and its outstanding speakers from the athletic and medical professions can be found elsewhere in this issue of THE JOURNAL. Dr. Garland Anderson of Fort Wayne is the coordinator of this fine presentation.

The second project of the Committee on Sports and Medicine was to research for a program that would provide greater availability of athletic trainers to the secondary school systems of Indiana. The committee felt that greater paramedical help was needed in the field of athletics. The need for care is on the increase, due to the number and size of programs presently being developed and implemented for women. A program was needed that would provide excellent care for each and every athlete. "Indiana Sports and Medicine Program" was presented to our committee by two members of the National Athletic Training Association—Mr. Pinky Newell of Purdue University and Mr. Dick Hoover, presently in private practice of physical therapy at Glenview, Ill. They presented a proposal directed toward the planning, organization and implementation of a comprehensive and viable sports-medicine program for the State of Indiana. This program would encompass all of the planned and coordinated activities of professional and voluntary workers whose roles in society are relevant to the concept of sports

medicine; i.e., all phases of physical conditioning, athletic training, prevention, treatment and rehabilitation of sports injuries. This would include the involvement of coaches, school administrators, student volunteers, equipment managers, parents and allied health personnel responsible for the administration of medical services and first aid to sports participants.

The state of Indiana is unique in having four state universities offering an approved curriculum in undergraduate athletic training education. Unfortunately, the need in the 500-plus high schools cannot be met by this method of education and placement. The comprehensive program proposed would hopefully satisfy the need for a qualified, educated, certified athletic trainer in each high school at the end of five years. The program would continue to fulfill the need of replacement personnel as normal turnover occurs.

This program will be discussed at the annual meeting on Oct. 21 in French Lick. Presently, means to provide funding for the institution of this or a similar program are being investigated by our committee. In 1975-76, the committee will continue to bring to reality this sort of program of athletic training personnel in Indiana.

Also, another project will be undertaken in 1975-76. The Committee on Sports and Medicine will endeavor to set up a protocol for a practical program for medical safety in elementary, intermediate and senior high schools, and for community sports and recreation programs such as little league, park and recreation departments and similar groups. It will also help to publicize the availability of such a protocol to the public, in particular to physicians who may be involved, and to make this available wherever needed through local medical advisors.

BRAD BOMBA, M.D.

Chairman

ARTHUR L. MOSER, M.D.

ALOIS E. GIBSON, M.D.

WILLIAM B. FERGUSON, M.D.

GARLAND D. ANDERSON, M.D.

LESLIE M. BODNAR, M.D.

ROLLA D. BURGARD, M.D.

WARD BROWN

SCOTT WILHELMUS

GILBERT M. WILHELMUS, M.D.

JAMES H. BELT, M.D.

PAUL A. WILLIAMS, M.D.

Student Loan

No student loan applications were received this year. Furthermore, no applications have been received since 1970. The federal guaranteed loan program has been discontinued and consequently more students are needing financial help. The Indiana State Medical Association student loan fund, when compared to the American Medical Association-ERF guaranteed loan fund, requires more guarantors or co-signers (one of which must be the spouse); the rate is higher and repaying term is earlier; therefore, the student finds it much easier and beneficial to receive the AMA-ERF loan.

At our meeting the loan committee, following the 1974 House of Delegates' recommendations, first considered transferring the guaranteed fund to AMA-ERF but subsequent discussions with the Indiana National Bank of Indianapolis, our financial participant, has resulted in more realistic changes in our agreement with them. Mr. Malcolm Buck, the assistant vice president of the Indiana National Bank; Mr. Jay Smith, financial assistant to Dr. Steven C. Beering, dean of the Indiana University School of Medicine, and your chairman have been in lengthy discussions and recently have arrived at a tentative agreement on amendments to the present loan agreement which would bring the ISMA student loan fund to almost parallel requirements with that of the AMA-ERF. It is hopeful that these changes will allow for easier and greater participation by the Indiana University medical students of the ISMA student loan fund. Final details of this amendment will be announced to the Board of Trustees for action and will be discussed with the membership at the annual meeting in French Lick.

MALCOLM O. SCAMAHORN, M.D.

Chairman

JOE DUKES, M.D.

PAUL HOLTZMAN, M.D.

JAMES O. RITCHEY, M.D.

HUGH K. THATCHER, JR., M.D.

STEVEN C. BEERING, M.D.

RICHARD FAIRCHILD

A financial contribution has been received from A. H. Robins Company and Geigy Pharmaceuticals to assist with the educational program at the 1975 Convention.

Reports of Commissions

Aging

The Commission on Aging met on March 2, April 16 and June 1, 1975, to discuss the Nursing Home situation in Indiana.

Mr. George Heighway of the Indiana State Board of Health was invited to the first meeting to answer questions and give information about what the State Board of Health is doing to control the operation of nursing homes.

Mr. Heighway answered questions about licensing of nursing homes, inspections, profits, relationship between the pharmacist and nursing home and how the Board of Health felt about patients going directly from their families to a nursing home instead of being evaluated first by their physicians.

It was decided that before you can address the nursing home situation attention must first be paid to the population which nursing homes serve—namely, the aged.

The truth is, the aged represent one of the most disadvantaged groups in American society. Approximately one third of all aged Americans are plagued by poverty. Their needs for medical and social services greatly increase at just the time when their ability to pay for such services greatly diminishes, either through retirement or disability. Therefore, the commission feels some external sources are needed by the aged to help at that particular stage in life with the multitude of problems which beset them.

Although there have been some excellent interventions by private external sources such as friends, families, churches, and other charitable groups, a unified, pervasive, effective external source of intervention into these problems for the multitudes of aged in American society has not occurred.

Obviously one external source of intervention might be the government. However, there is still a feeling that each of us should be responsible for his own existence. It is felt that the government is best which governs least.

But there is a growing feeling in our country that stable financing and good care and planning for the needs of the elderly cannot be separated.

The nursing home industry currently receives three quarters of its income from government, and it appears the government will be playing a larger role in nursing home care in the future.

The commission feels we should recognize these trends and do all we can to insure positive programming for the elderly as a result of these trends.

Because of this, the Commission on Aging makes the following recommendations:

1. The funds poured into nursing homes might be better utilized in the provision of day care centers, meal delivery and transportation services to elderly living in their own homes or apartments.

2. Nursing homes should be accredited and licensed by appropriate boards and agencies.

3. The home should be free of accident causing hazards. It should meet state and federal fire safety codes, and there should be obvious evidence of fire safety precautions.

4. Living arrangements should be comfortable and properly equipped. Toilet facilities should accommodate wheelchair patients. The home should be clean, reasonably free of unpleasant odors, and the hallways should be well lighted and reasonably wide.

5. The dining room should be attractive and inviting, and the food nutritionally adequate and tasty. The kitchen should be clean, and there should be some dietary supervision. Normal mealtime should be observed with plenty of time for leisurely eating. Patients who need help in eating should have it available.

6. Rooms for recreational pursuits, private visits, special purpose physical examination rooms, and an isolation bedroom and bathroom should be available.

7. A well established protocol to meet medical emergencies should be operational. Complete and accurate health care records should be kept on every patient, and ready access to a nearby hospital for acute hospitalization should be provided.

9. There should be a sufficient number of registered nurses on duty 24 hours a day and with sufficient L.P.N.s and nurses' aides. Nursing home directors, nurses, L.P.N.s, aides, and ancillary help should be carefully chosen and exposed to in-service training continuously. L.P.N.s should be given the same status as R.N.s in nursing homes because of the shortage of R.N.s.

10. Physicians should be urged to see their patients at regular intervals, and this should be continually emphasized by the State Medical Association to its members.

11. Physicians should be given tax credits for calls on patients in nursing homes.

12. Beds in nursing homes should not be classified, but patients should be.

13. Homes for the aged, nursing homes and county homes must be medical institutions so that at least some older people who enter will be rehabilitated and returned to their communities.

The Commission on Aging realizes that some of these recommendations are already in effect concerning nursing homes, but it is felt that not all of them are being followed at the present time.

It has been stated that the industry is earning high profits while providing poor

patient care. The Moss congressional hearings, television and other news media have exposed considerable swindling of government funds throughout the country. Manipulation of ownership and of mortgages has been brought to light.

Apparently there is little effort put forth to enforce the nursing home regulations as they now exist. Industry lobbyists are influential at the state level in order to insulate some of these homes from proper discipline, and public pressure is lacking to enforce nursing home regulations.

Therefore, the Commission on Aging recommends that it is time for another evaluation of the county homes and nursing homes in Indiana by the proper officials.

As chairman of the commission, I wish to thank the members of the Commission on Aging for their participation. The meetings were productive and I sincerely hope that our endeavors will be of some value in improving the care of the aging in our nursing homes.

NATHAN L. SALON, M.D.

Chairman

JOHN D. WILSON, M.D.

ROBERT O. BETHEA, M.D.

JOSEPH C. DUSARD, M.D.

SHERMAN G. FRANZ, M.D.

PAUL E. HUMPHREY, M.D.

ALBERT M. DONATO, M.D.

D. L. BUCKLES, M.D.

W. MARTIN DICKERSON, M.D.

DANIEL RAMKER, M.D.

LOWELL J. HILLIS, M.D.

PETER CLASSEN, M.D.

A. W. CAVINS, M.D.

T. R. HAYES, M.D.

MISS SALLY THOMAS

Emergency Medical Service

The Commission on Emergency Medical Service met on Sunday, April 13, at ISMA headquarters office. The purpose of the meeting was to review the activities of the Governor's Commission on Emergency Medical Service and to insure the protection of the interests of the physicians of the state in the implementation of these activities and, also, to develop a means of input into the actions and activities of the Governor's Commission. Consequently, Philip K. Martin, the executive director of the Governor's Commission, was invited to the meeting.

Mr. Martin distributed copies of the final emergency medical service rules and regulations which had been submitted to the Governor for implementation, pointing out that the formulation of these rules and regulations had been of priority concern to Dr. Dillon, the chairman of the commission, and that most of the efforts of the commission had been directed in preparing this document over the past year. Presently, the commission is involved in other activities such as additional funding for EMS services, the

training of emergency medical technicians, and the development of county and regional systems as recommended by the American Medical Association.

The House of Representatives recommended a budget about half what the commission asked for and the Senate bill reduced this figure about 75%. Mr. Martin pointed out it would be impossible to carry out the activities of the commission with this kind of budget. Funding from various sources is available but never has been coordinated, and it is the endeavor of Mr. Martin to accomplish this, plus allocating these monies where they are most needed. A detailed county-by-county survey to determine the kinds of equipment on hand and other details of current emergency medical service programs in operation is to be done.

Current training programs and certification of EMTs throughout the state were discussed. Indiana Vocational Training College of Indiana (Ivy Tech) has been contracted to provide this training in most areas of the state. This was convenient because Ivy Tech was in existence and structured to perform the job; however, it was the consensus of the physicians present at the meeting that they (the physicians) were being left out of this program and were not being consulted or informed of the extent of EMS activities in their own communities. Mr. Martin agreed that in order for the training programs to be effective, physician involvement must be encouraged and that doctors should be doing the instructing of EMTs.

Another area of concern was the establishment of a regional system of coordinating centers by the Governor's Commission. These centers were selected by the commission with the assistance of the Indiana Hospital Association. These centers are to have money channeled to them for EMT training and other aspects of local emergency medical services; and they, in turn, would be responsible for allocating funds in the areas they felt were necessary. Again, it was pointed out that in most cases physicians were not generally aware of these selections and it was felt that the members of the county medical societies should have been consulted.

There were other points discussed, such as the possible realignment of EMS areas because of the National Health Services Act, and patient referral guidelines being established in some areas of the state without the knowledge of Mr. Martin or the Governor's Commission. Mr. Martin stated that there was much activity going on outside the realm of responsibility of the commission. He suggested that the ISMA Commission on Emergency Medical Service keep a line of communications open with the Governor's Commission through the physician who is on that commission. He stated he would make every effort to work in conjunction with the ISMA Commission on EMS

and involve local doctors more in the planning.

As a result, a motion that a letter be written to the Governor's Commission from the ISMA Commission on EMS asking them what they would like for the physicians of the state to be doing regarding the development of emergency medical services planning and programs was moved, seconded and passed. Also, a motion was seconded and passed that the physician appointed to the Governor's Commission be made a member of the ISMA Commission on EMS.

The commission discussed the need for the establishment of a Section on Emergency Medicine within the framework of the ISMA. This would have to be done through a resolution passed by the House of Delegates at the next annual meeting. There will be resolutions submitted to this effect.

The commission felt that ISMA should have official representation at a May meeting of STEP (Society for Total Emergency Programs) in Indianapolis. The Executive Committee of ISMA approved this and Dr. John Suelzer was asked to attend.

Another meeting with Mr. Martin was planned for July 13, 1975.

MARTIN J. O'NEILL, M.D.

Chairman

LARRY W. SIMS, M.D.

ROBERT M. WALKER, M.D.

CHARLES B. CARTY, M.D.

H. S. RILEY, M.D.

DONN R. GOSSOM, M.D.

ARLINGTON M. HUDSON, M.D.

HOWARD WILLIAMS, M.D.

DAVID J. DIETZ, M.D.

G. R. BOUGHER, M.D.

THOMAS R. SCHERSCHEL, M.D.

JEROME H. WAIT, M.D.

DONALD S. CHAMBERLAIN, M.D.

JOHN G. SUELZER, M.D.

MARTIN J. GRABER, M.D.

JAMES D. FINFROCK, M.D.

ROBERT R. TAUBE, M.D.

LARRY COX, M.D.

B. D. WAGONER, M.D.

THOMAS LIFFICK

Governmental Medical Services

Only one meeting of the commission was held at which reports were received from the district and national HEW representatives on PSRO in Indianapolis, HMO, and from the State Welfare Director for Medicaid of Indiana. The results of these reports were published in a previous edition of this year's JOURNAL of the Indiana State Medical Association.

The role of the commission has primarily been that of information gathering. The commission could assume other roles but has not been asked to do so by either the Board of Trustees, the Executive Committee, or the House of Delegates of the ISMA.

The role of the Governmental Medical Services Commission has not been clari-

fied as far as the existing commission is concerned in the upcoming report on reorganization of commission structure to be submitted by the Future Planning Committee of the ISMA.

Included in the final structure of the Commission should be the following:

1. Clear role definition for the new body concerned with governmental medical services.

2. An interrelationship on an ongoing basis with the various governing bodies and with the investigative bodies.

3. A method of developing leadership with expertise in specialized fields of study (social, economic and legislative matters particularly) that will serve all the membership as well as broaden the base of participation of members in ISMA affairs.

LEE H. TRACHTENBERG, M.D.

Chairman

HENRY J. RUSCHE, M.D.

FLORIAN S. DINO, M.D.

FRED D. HOUSTON, M.D.

J. FRANKLIN SWAIM, M.D.

O. LYNN WEBB, M.D.

JEROME E. HOLMAN, JR., M.D.

ROBERT A. MORRIS, M.D.

LOWELL R. STEPHENS, M.D.

JAMES D. REID, M.D.

EVERED E. ROGERS, M.D.

JOHN J. DeFRIES, M.D.

GERALD P. IRWIN, M.D.

L. R. COPELAND, M.D.

MARK BECHTEL

Interprofessional Relations

The Commission on Interprofessional Relations met three times during the year.

One of the major topics of discussion was the Joint Practice Commission and the status of its activities. The commission had been organized during 1974 with representatives named from the Indiana State Nurses Association and the ISMA. The group had then drawn up a constitution and bylaws, following which the ISMA and the ISNA had allocated a \$1,000 grant, on a one-time basis, to the commission to assist in beginning its work toward the solution of some of the problem and priority areas which had been agreed upon by the commission.

Following the gathering of data by the staff on the Joint Practice Commission's activity and a report by Dr. Gabriel Rosenberg, who had been chairman of the ISMA Commission on Interprofessional Relations and vice chairman of the Joint Practice Commission, it was learned that little had been undertaken by the Joint Practice Commission; and the funds allocated had never been utilized.

The activity of the Joint Practice Commission had been somewhat thwarted by the unreported nurse chairman's withdrawal from membership in the Indiana State Nurses Association. Cooperation between the ISNA and ISMA was

further complicated by the apparent unwillingness of the ISNA to work co-operatively with the ISMA in legislative support, especially in the effort expended toward solution of the professional liability crises in Indiana. President Wilhelmus had so advised the Nurses Association of this matter.

At the time of this report the ISMA had cancelled payment on the grant of \$1,000 to the Joint Practice Commission.

Because of the critical nature of the professional liability crises in Indiana, the commission also discussed the need for a continuing communication between the legal and medical professions in Indiana. This was additionally emphasized by the commission's concern toward obvious leaks in information from some hospitals to plaintiff attorneys concerning patients who might have potential grounds for suits against doctors.

Following considerable discussion of both matters in which the legal counsel of the Indiana Hospital Association met with the commission to discuss both areas of concern, the commission recommended to the Board of Trustees of the ISMA that top officers of the Indiana State Bar Association and the ISMA meet periodically to discuss common problems regarding medical and legal interests.

The commission also discussed a proposal of the Indiana State Nurses Association concerning the return of the student nurse to the operating room for experience. The Indiana State Nurses Association had pointed out that they had circulated a questionnaire to 135 hospital directors of nursing and to 30 directors of schools of nursing to gather data on the need for reaching a goal for more education in the operating room. The returns on the questionnaire indicated overwhelmingly that the hospitals and schools favored this objective.

The type of training for student nurses was favorably discussed by the commission, which recommends that such training be encouraged by the membership of the Indiana State Medical Association.

The commission also during the course of its year heard a detailed report on the current status of the physician assistant program in Indiana and throughout the nation from Dr. Raymond Murray, director of the Regenstrief Institute and the Department of Community Health Services at Indiana University School of Medicine.

Some of the points made by Dr. Murray included the following:

1. Twelve P.A.s were graduated last year from the I.U. course at Fort Wayne and eighteen more will be graduated in August 1975.

2. There have been 56 family nurse-practitioners trained in the past three months, with 22 additional nurse practitioners to begin training in July 1975.

3. There are 50 approved P.A. programs in the U.S. today. Such approval is

granted by the American Medical Association, the American Academy of Family Practice and one or two other national medical bodies.

4. Dr. Murray expressed the thought that the Board of Licensure should have control over P.A.s concerning definitives for what they can do and requirements for certification or registration.

5. The P.A. can only carry out those activities in a hospital which are predetermined by the hospital staff. In some hospitals they can write orders; in others they are not permitted in the hospital.

6. Concerning professional liability problems, there is no record of a doctor in Indiana, who is utilizing a P.A., having been sued.

Additionally, during the course of the year the commission made efforts on two occasions, unsuccessfully, to meet with the Indiana Pharmaceutical Association representative to discuss common problems.

MARVIN E. PRIDDY, M.D.

Chairman

ALBERT S. RITZ, M.D.

JACK L. SHANKLIN, M.D.

WILLIAM E. SCULLY, M.D.

MARK E. SMITH, M.D.

CLYDE G. CULBERTSON, M.D.

AMBROSE PRICE, M.D.

JACOB SCHEERES, M.D.

MITCHELL E. GOLDENBURG, M.D.

J. DEAN GIFFORD, M.D.

WILLIAM J. STOGDILL, M.D.

RICHARD W. HOLDEMAN, M.D.

RICHARD L. VEACH, M.D.

GABRIEL J. ROSENBERG, M.D.

Legislation

The first session of the 99th General Assembly of Indiana was one which had medical legislation as its major action. The Ad Hoc Committee on Medical Liability Insurance, chaired by President Gilbert M. Wilhelmus, M.D.; William Cast, M.D., and Paul Muller, M.D., did a magnificent job in getting Indiana's medical liability landmark bill through both Houses and signed. The Auxiliary and our entire membership need to be recognized for their outstanding help. A special report will be made by this committee to the House of Delegates.

The other piece of medical legislation presented to the legislature was the Medical Practice Act. It was a revised version of the Act approved by the 1974 House of Delegates. Specifically it (1) did *not* contain anything regarding the Physician Assistant, (2) did add *suspension and probation* to the powers of the Board of Medical Licensure, and (3) did make it *easier for the foreign medical graduate to qualify for state licensure examination* because it did require the foreign medical graduate to either have two years of approved hospital training prior to his examination or, if no approved hospital training, to remain in Indiana on a

preceptorship for two years—but not to do both as was required in the previous bill. (It is suggested that the 1975-76 Commission study and support a Physician Assistant Act which is being prepared for introduction to the legislature.)

The Medical Practice Act passed without great opposition; however, in the last days of the session, Senate Bill 111, which had been opposed by the Indiana State Medical Association, did, by joint committee recommendation, receive passage as an amendment to the Medical Practice Act. This amendment was subsequently vetoed by Governor Bowen. S.B. 111 would allow any foreign medical graduate applicant who held an ECFMG certificate to be given full licensure in Indiana without examination and then a two-year preceptorship would be required within the state. Southern Indiana, Inc. and the bill's sponsor have called for an override of Governor Bowen's veto. Your commission is sure that such an override will be attempted. ISMA is opposed to this amendment to the Medical Practice Act and will support Governor Bowen's veto.

More than 100 bills were studied by your Commission on Legislation as relating directly to physicians and to the health care of Indiana. There were studies and recommendations as to whether any of these bills would be (1) supported, (2) opposed or (3) taken for information only. The subjects were from such areas as restaurant laws, contraceptive advice, higher education, acupuncture, and through the gamut of all kinds of things such as insurance in general, workman's compensation, and vehicle operator's license. A total of six meetings was held during the session, and the attendance was very excellent from all trustee areas. The Auxiliary was always represented and their help was deeply appreciated.

It was a successful session for medicine, but the Commission feels that in the future all proposed medical legislation should be handled by one committee, since communications and flaking side issues can become confusing for the legislators and the ISMA legislative staff as well. This breakdown in communications and in the side issues of the various proposed acts often causes problems. The Commission wishes to recognize the ISMA staff for their excellent support and leg work.

Outstanding this session was the attendance at the Commission meetings of the three physician legislators—Floyd Coleman, M.D., of Waterloo, E. Henry Lamkin, Jr., M.D., of Indianapolis, and Anthony Pizzo, M.D., of Bloomington. Their opinions and discussions were most helpful not only to the Commission but to the Ad Hoc Committee and they were most invaluable in certain key decisions.

The Commission will continue to hold interim meetings if necessary before the next session to prepare any new legisla-

tion or study new proposed legislation and, if necessary, an amended report will be filed at the annual meeting in French Lick.

MALCOLM O. SCAMAHORN, M.D.

Chairman

JOHN A. KNOTE, M.D.

ROBERT M. SWEENEY, M.D.

THOMAS HARMON, M.D.

IVAN A. CLARK, M.D.

JOE BLACK, M.D.

WILLIAM BANNON, M.D.

JOHN A. DAVIS, M.D.

JOHN PANTZER, M.D.

RICHARD L. REEDY, M.D.

A. P. BONAVENTURA, M.D.

RICHARD L. GLENDENING, M.D.

JERRY L. STUCKY, M.D.

DON WOOD, M.D.

JAMES KIRTLEY, M.D.

FRED SMITH, M.D.

JOSEPH McPIKE, M.D.

LEONARD W. NEAL, M.D.

JOHN B. WHITE, JR., M.D.

MARY FORSTER

MRS. JACK WALKER

MRS. WILLIAM RAGAN

any reduction in malpractice insurance. Our suggestion at this time is to keep the insurance that you now have in force. If you are unable to obtain insurance, you will have to become a member of the "pool" which is explained in the law.

The Commission goes on record that we recommend the "occurrence type" policy and not any "claims-made" policies.

ROBERT O. ZINK, M.D.

Chairman

Leo R. NONTE, M.D.

ROGER F. ROBISON, M.D.

FRANCIS H. GOOTEE, M.D.

JACK G. WEINBAUM, M.D.

ROBERT P. INLOW, M.D.

FREDERICK EVANS, M.D.

LARRY G. COLE, M.D.

HARRY TO STOUT, M.D.

R. JAMES BILLS, M.D.

WILLIAM R. CAST, M.D.

ROBERT D. CHANEY, M.D.

ROBERT C. STONE, M.D.

WALLACE S. TIRMAN, M.D.

JACK W. HANNAH, M.D.

JOEL W. SALON, M.D.

R. ADRIAN LANNING, M.D.

PAUL M. INLOW, M.D.

THOMAS J. CONWAY, M.D.

STEVE RATCLIFFE

Medical Economics and Insurance

It is with a feeling of regret that we must report the untimely death of Dr. K. O. Neumann, who had been chairman of the Commission for so many years. He took with him a great deal of the work and planning that was carried on up to that time.

A meeting was held by the Commission on May 28th at the headquarters building, at which time we heard from Aetna Life and Casualty, which is not interested in writing any malpractice insurance at all, and Hartford Insurance Company, which is not planning on increasing their coverage. St. Paul Fire and Marine Insurance Company will only write "claims-made" policies as of July 1st this year. They have enrolled approximately 800 doctors in the state. The Travelers Insurance and U.S.F.&G. were not present. The Medical Protective Company is not seeking any new business with the exception of the newly graduated M.D's. We had reports from CNA who showed an interest in working up a statewide program which would cover all the physicians in Indiana under one policy.

As of the date of this report, there have been no hard and fast rules established either by our society or the state Insurance Commissioner as to the exact nature of our insurance availability, or how much the rates will be. Rest assured that your Commission will keep abreast of the developments of the various companies, i.e., any change in rates that might occur or rates being lowered due to our new law that has taken effect. Frankly, it seems very possible that it will be at least 2 years before there is

Medical Education and Licensure

The Commission and its Accreditation Committee each held three meetings during the past year. The major work of the Commission included:

(1) Review of Site Team Survey and accreditation materials concerning Indiana hospitals and specialty societies.

(2) Approval of the following hospitals and societies:

Huntington Hospitals, Huntington
St. Mary Mercy Medical Center, Gary
Bloomington Hospital, Bloomington
Lafayette Medical Foundation,
Lafayette

Methodist Hospital of Indiana,
Indianapolis

Gary Methodist Hospital, Gary
Caylor-Nickel Clinic, Bluffton
Indiana Philippine Medical Society
Indiana Society for Internal Medicine
Indiana Psychiatric Society
St. Catherine Hospital of East Chicago
St. Joseph Memorial Hospital,
Kokomo

(3) The development and display of a Continuing Medical Education booth at the 1974 State Convention to promote the Physician Recognition Award and the Accreditation Program.

(4) Review and approval for Category I Accreditation of the scientific portion of the 1975 ISMA Convention Program.

(5) Provision of a validated record of meeting attendance for annual convention participants.

(6) Provision of a monthly printout of Indiana physicians receiving the Physician Recognition Award as well as the

provision of a gold ISMA membership card and the addition of the ISMA seal to the PRA certificate. In the first five months of 1975, 125 Indiana physicians qualified for the PRA.

(7) Members of the Commission actively participated in the legislative efforts concerning the Medical Practice Act and the Patient Compensation Act.

(8) The Commission again participated in the planning and implementation of the Annual Student-Physician-Faculty Retreat which was held in March 1975 at the Brown County Inn in Nashville. The complete report of this Retreat will be published in a future issue of the ISMA JOURNAL.

(9) The following Commission members deserve special recognition for acting as liaison officers with other organizations during the year:

Dr. Ellis, Dr. Stogsdill, Mr. Roscoe—
CONVENTION ARRANGEMENTS

Mr. William Beeson—MEDICAL
STUDENT AFFAIRS

Dr. Dan Lowe—HOUSESTAFF AFFAIRS

Dr. Cullison, Dr. Wagner—GRADUATE MEDICAL EDUCATION AND THE ASSOCIATION OF INDIANA DIRECTORS OF MEDICAL EDUCATION

Dr. Franklin Bryan—BOARD OF TRUSTEES AND LEGISLATIVE LIAISON

Dr. Ross Egger—INDIANA ACADEMY OF FAMILY PHYSICIANS AND CME COMMITTEE OF THE COUNCIL ON MEDICAL EDUCATION

Dr. Merritt Alcorn—INDIANA MEDICAL LICENSING BOARD

STEVEN C. BEERING, M.D.

Chairman

GILBERT M. WILHELMUS, M.D.

JEAN ARTHUR CREEK, M.D.

RICHARD RIEHL, M.D.

STANLEY FRODERMAN, M.D.

DAVIS W. ELLIS, M.D.

DONALD M. SCHLEGEL, M.D.

HAROLD E. NELSON, M.D.

RICHARD R. HUGHES, M.D.

NICHOLAS L. POLITE, M.D.

SHOKRI RADPOUR, M.D.

RONALD H. SCHEERINGA, M.D.

THOMAS A. ELLIOTT, M.D.

LESLIE BAKER, M.D.

LINDLEY WAGNER, M.D.

JOHN L. CULLISON, M.D.

ROSS L. EGGER, M.D.

MERRITT O. ALCORN, M.D.

WILBERT McINTOSH, M.D.

JOHN ROSCOE

WILLIS STOGSDILL, M.D.

EUGENE M. GILLUM, M.D.

WILLIAM BEESON

DANIEL K. LOWE, M.D.

FRANKLIN A. BRYAN, M.D.

Public Health

The Commission met twice during the period October 1974-June 1975.

At the first meeting in December

1974. Dr. James Johnson was elected vice-chairman and Dr. Robert Seibel was elected secretary. The annual report of the Commission was reviewed and the minutes of the last previous meeting were abstracted for discussion.

It was recommended that a position paper from the Citizens League for Nursing, previously referred to the Board of Trustees, be reevaluated and recommended for conference with the League, if the Board of Trustees concurred. The paper was endorsed in principle but important modifications were needed for unequivocal support from the Association.

The Commission heard an in-depth presentation from Dr. James F. Bowes, Dow Chemical Company, in support of a compulsory vaccination statute for Indiana.

The Commission recommended that the authority of the Superintendent of Public Instruction be investigated to determine his ability to require, by regulation, immunization as a prerequisite to school entrance.

Dr. Robert Yoho, Assistant State Health Commissioner, discussed the matter of regionalization of local health departments. Dr. Yoho pointed out that some structure, by whatever name, is needed to strengthen and thus permit local health departments to be more effective. Dr. Yoho predicted that the upcoming Legislature would discuss this matter and refer it to a study committee.

The Commission restated its support of this concept and recommended that the ISMA Legislative Commission support this position.

Mature consideration was given to a proposal from the Indiana Lung Association (formerly, Indiana Tuberculosis Ass'n.) for repeal of the law requiring tuberculosis tests for children entering school.

The Commission opposed repeal of this law pending demonstration of the value of such repeal.

There was extensive discussion of a proposal from the Department of Mental Health regarding repeal of the law concerning public intoxication. The major impetus for such repeal lay in the concept that upon arrest for public intoxication the person so arrested could be placed in a treatment facility. The commission noted that the present law has such a provision and that there was inadequate basis for repeal cited in the presentation.

In view of the tenuous basis for repeal, the Commission did not find it advisable to approve or disapprove the proposal.

The Commission reviewed a request from the Indiana University Developmental Training Center for a list of medical personnel interested in retarded and/or disturbed children.

There being no such information available in the Association, the Center was to be so informed.

Subsequently, the Commission learned that the Superintendent of Public Instruction could not require immunization as a prerequisite for school entrance.

The Commission also approved the program of the Immunization Action Month Committee as an ongoing effort to increase the immunization level of children in Indiana. This was a restatement of the previous year's recommendation.

Mr. Robert Sullivan, ISMA staff, presented a public information program for immunization education. It was noted to be both well-conceived and oriented. The Commission recommended that the Board of Trustees adopt the proposed plan of action.

The chairman expresses gratitude to the members of the Commission for their continued support and participation and to Mr. Bush for his aid as a staff representative.

A. C. OFFUTT, M.D.

Chairman

A. W. BROCKMOLE, M.D.

EDGAR CANTWELL, M.D.

R. M. SEIBEL, M.D.

JAMES JOHNSON, M.D.

F. B. WARRICK, M.D.

B. L. STEGER, M.D.

K. W. KOSS, M.D.

PATRICIA GALLAGHER, STUDENT

B. A. WORK, M.D.

HERSCHEL BORNSTEIN, M.D.

W. K. NEWCOMB, M.D.

J. J. HARRIS, M.D.

R. E. NELSON, M.D.

HUBERT GOODMAN, M.D.

N. L. NEIFERT, M.D.

E. A. CAMPAGNA, M.D.

RICHARD G. HUBER, M.D.

Public Information

The Commission on Public Information met in January, February, April and June 1975.

The commission's first matter of business was to get final approval of the information contained in the insurance pamphlet, "You and Health Insurance," drafted by Dr. Ahler, a member of the commission. This was accomplished and the pamphlet was printed by the Franklin Printing Company at a cost of \$2,000 for 100,000 copies. It was decided by the commission that each doctor would receive one copy free with additional copies available at three cents per copy. The pamphlet was produced to provide the patient with some basic guidelines regarding health insurance so they would be better equipped to make sound judgments regarding the financing of their future health care needs.

Tel-Med, a toll-free telephone medical information service of ISMA which has been widely acclaimed as an excellent piece of public relations, is now available to the blind. The commission, acting upon a request from St. John's Hickey Memorial Hospital, contacted Mrs. Har-

riett Whitson who agreed to transcribe the Tel-Med pamphlet into braille. After this was completed, the Indiana School for the Blind printed it and it was distributed by Headquarters Staff to the proper blind outlets in the state.

The Speakers Bureau is now operational and functioning quite well. The speakers were briefed on the medical liability problem and incorporated the information into their presentations. The speakers reported they received many questions concerning the problem during their speaking engagements. One speaker, Stan Evans, moved to Washington, D.C., which cut the speakers available to three. However, Joel Marsh was interviewed at the June meeting as a possible speaker. More speakers are needed if the program is to be a continued success.

Another public relations program the commission is trying to implement is one which will provide 30- and 60-second spot announcements to radio and television stations around the state about medical information. At the present time the commission is talking with Mr. Tim Spencer, proprietor of Free Lance Associates and a member of the Speakers Bureau, about getting the program off the ground. One possibility is his Bicentennial program called "The Quest for Freedom," which is about the Revolutionary War period. The program would cost \$17,000 for one year and would allow the Association to insert 60-second spot announcements prior to the information about the Revolutionary War being heard. This program would be sold to 20 communities around the state and would be played for 13 weeks in each area. The Board of Trustees of the Indiana State Medical Association has not yet given its final approval for this program. This commission intends this to be an ongoing program to supplement the Speakers Bureau.

The Commission also made its selections for the Journalism Awards and for the Physician Community Award. These awards will be presented at the Indiana State Medical Association's annual meeting in October.

The President of the Association was requested by the commission to write a letter of thanks to all media in Indiana and some TV stations in Chicago for their objectivity in reporting the medical liability crisis in Indiana.

Another suggestion forwarded to the Board of Trustees by the commission was that ISMA conduct an accountability session with the general public prior to their annual convention. It was felt this would be a good way to find out what the layperson is thinking about medicine and by letting them know physicians care is good public relations.

A pamphlet on High Blood Pressure which is proposed by Blue Cross and Blue Shield of Indiana, was approved by the commission and is now awaiting ap-

proval of the Board of Trustees. If it is approved, the front cover will state, "A Community Service Program of Blue Cross and Blue Shield of Indiana and the Indiana State Medical Association."

Finally, the commission unanimously voted to send a letter of commendation to Malcolm O. Scamahorn, M.D., for the excellent job he did on the Audio Tape "INFO" Program.

DAVID G. CRANE, M.D.

Chairman

CHARLES HACHMEISTER, M.D.

THOMAS O. MIDDLETON, M.D.

LOUIS H. BLESSINGER, M.D.

ROBERT P. ACHER, M.D.

MILTON HERZBERG, M.D.

HARRY T. HENSLEY, M.D.

PAUL BURNS, M.D.

KENNETH J. AHLER, M.D.

JOEL HULL, M.D.

EUGENE T. KARNAFEL, M.D.

JOHN C. HARVEY, M.D.

JOHN LUCE, M.D.

WILLIAM B. CHALLMAN, M.D.

ROBERT W. HARGER, M.D.

HARRY G. BECKER, M.D.

JAMES A. TATE, M.D.

LOUIE O. DAYSON, M.D.

ROSS L. EGGER, M.D.

FRED DAHLING, M.D.

Special Activities

Commission meetings have not been held this past year because the Commission on Special Activities has not been charged with any particular tasks or responsibilities by the President.

HANUS J. GROSZ, M.D.

Chairman

RICHARD B. HOVDA, M.D.

ROBERT E. CHATTIN, M.D.

JOHN P. SALB, M.D.

C. DAVID RYAN, M.D.

HUGH E. GLOCK, M.D.

JOSE S. CABIGAS, M.D.

DONALD HUNSBERGER, M.D.

FAE H. SPURLOCK, M.D.

DAVID E. ROSS, M.D.

GEORGE WAGONER, M.D.

NORMAN BEAVER, M.D.

THOMAS J. QUILTY, M.D.

PETER E. GUTIERREZ, M.D.

ROBERT P. ACHER, M.D.

RICHARD D. HAWKINS, M.D.

DWIGHT W. SCHUSTER, M.D.

CRAIG MOORMAN

Voluntary Health Agencies

The Commission on Voluntary Health Agencies met twice during the year to complete its business.

After review of the usual comprehensive reports which are required by the Commission from the state's voluntary health agencies who desire approval, the following agencies were placed on the Association's approved list for 1975-76:

American Cancer Society, Indiana

Division, Inc.

American Heart Association, Indiana Affiliate, Inc.

American Lung Association of Indiana Arthritis Foundation, Indiana Chapter Hemophilia of Indiana, Inc.

Indiana Committee to Combat Huntington's Disease, Inc.

Indiana Easter Seal Society for

Crippled Children and Adults, Inc.

Indiana Society for the Prevention of Blindness, Inc.

Kidney Foundation of Indiana, Inc.

Mental Health Association in Indiana The National Foundation, March of Dimes

National Multiple Sclerosis Society,

Indiana Chapter

Tri-State Epilepsy Association, Inc.

Once the organization are approved, their names are circulated via a placard to hospitals and individual physicians. The agencies also distribute thousands for the benefit of the contributing public.

As the program has grown over the past 12 years, the agencies seeking approval have increased and recognize the approval program as a vital part of their public acceptance as ethical organizations operating on a high level of fund-raising, research and community service programming.

Very active again this year were representatives of the Woman's Auxiliary, who assisted the commission in evaluating reports of agencies by meeting with committees and boards of agencies and in many other ways.

Also active again at Commission meetings were three representatives, elected by the agency executives to represent them.

On April 6, 1975 the commission held its annual session with executives and other officials of the voluntary health

agencies. This meeting has become a part of the format of the Commission's activities during each year. The meeting consists of an informal exchange of information between the Commission's activities and the current activities of the various agencies. Recommendations are made each year by all to aid in the continuance of good relations.

One of the joint projects now underway by the Commission and the agencies is the development of an informative booklet which would contain listings of the officials of the approved agencies, their services offered and programs conducted. The format is to be brief and concise with distribution to physicians, industries and other appropriate organizations throughout Indiana.

As chairman of the Commission I wish to express my sincere appreciation for the efforts of the Commission members, the Commission representatives of the Woman's Auxiliary, and for the fine spirit of cooperation of Indiana's voluntary health agencies.

LOWELL W. PAINTER, M.D.

Chairman

E. De VERRE GOURIEUX, M.D.

CHARLES W. McCLARY, M.D.

DONALD M. KERR, M.D.

ELTON HEATON, M.D.

JOHN ELLETT, JR., M.D.

DONN R. HUNTER, M.D.

CHARLES RUSHMORE, M.D.

LAWRENCE E. ALLEN, M.D.

ROBERT W. VERMILYA, M.D.

WALFRED A. NELSON, M.D.

WENDELL W. AYRES, M.D.

RUSSELL GRAF, M.D.

HARRY STIMSON, M.D.

ALVIN T. STONE, M.D.

ROBERT W. BRIGGS, M.D.

JOSEPH W. YOUNG, M.D.

ANTHONY COSSELL

HAROLD R. WARD

WILLIAM C. WILSON

MRS. RALPH B. MILBURN

MRS. JAMES GUTHRIE

MRS. HERBERT SEDAM

MRS. RONALD KLEOPFER

MRS. RICHARD McILROY

MRS. PHILIP L. SMITH

MRS. HAROLD R. WIREY

MRS. J. J. LIND

MRS. A. WAYNE RATCLIFFE

MRS. JACK WALKER

ADDITIONAL REPORTS and information with regard to the Annual Meeting Oct. 20-22 at French Lick will appear in the October issue of THE JOURNAL.

Resolutions

Resolution No. 75-1

Introduced by: John W. Luce, M.D.,
Delegate from LaPorte County

Subject: CREATION OF A SECTION ON ORTHOPEDIC SURGERY

Referred to:

Be it resolved, That Chapter III, Section 1 of the Bylaws, be amended by adding a new line "r" to read "Orthopedic Surgery"; and be it further

Resolved, That the present line "r" be relettered line "s."

Resolution No. 75-2

Introduced by: Section on Allergy

Subject: CREATION OF DEPARTMENT OF ALLERGY AND IMMUNOLOGY AT INDIANA UNIVERSITY SCHOOL OF MEDICINE

Referred to:

Whereas, 25-30% of patients seen by pediatricians are for an allergic problem; and

Whereas, More time is lost from school by children and teenagers because of allergic disease than from any other cause; and

Whereas, There are an estimated 50,000 asthmatics in Marion County alone; and

Whereas, Every state surrounding Indiana has medical schools with departments of allergy and immunology and accredited training programs in allergy and immunology; and

Whereas, Indiana University School of Medicine has no such department of allergy and immunology nor any training program in this subspecialty; and

Whereas, Because of this, graduates of Indiana University School of Medicine are deficient in their ability to diagnose and treat allergic disease to the detriment of 15% of the population of Indiana; and

Whereas, Also because of Whereas No. 5, those interested in furthering their training in allergy and immunology must leave the state for this training and seldom return to Indiana to practice; and

Whereas, This has created a severe shortage of trained allergists in the state so that patients must frequently travel many miles and wait long periods of time to be seen and evaluated by properly trained men so that many go without proper care because of this scarcity of doctors trained to understand and care for these specialized problems; and

Whereas, Since allergy training now

consists of a conjoint Board of Allergy and Immunology and is a subspecialty in either internal medicine or pediatrics, and consists of two years of training in either of these specialties followed by two years training in allergy and immunology; therefore, be it

Resolved, That the House of Delegates of the Indiana State Medical Association vote favorably on a resolution to use whatever means possible to overcome this deficit which degrades Indiana University School of Medicine as a proper training center for doctors and is not in the true interest of the citizens of Indiana; and be it further

Resolved, That a Department of Allergy and Immunology and residency or fellowship training program in the same be created at the Indiana University School of Medicine; and be it further

Resolved, That the members of the Section on Allergy of the Indiana State Medical Association promise their support in helping train these men, inasmuch as properly treated allergy patients seldom require hospitalization (such as the prevention of status asthmaticus in most patients by proper allergic management) and most allergic problems are office or clinic problems; and be it further

Resolved, Therefore, that we shall be happy to assist in proper preceptorship programs and lectures and conferences to supplement residency training programs so that Indiana University School of Medicine will not be looked upon as a second-rate medical school because of this. Ultimately, the citizens of Indiana will greatly benefit from this and this is the reason the taxpayers support a medical school in Indiana.

Resolution No. 75-3

Introduced by: Vanderburgh County Medical Society

Subject: TRAVEL EXPENSE

Referred to:

Whereas, Financial stresses and fiscal restraints have been imposing restrictions and retrenchments upon programs of the Association; and

Whereas, Physicians generally practice economies in their personal expenditures, including air travel at tourist rates rather than first-class fares; therefore, be it

Resolved, That it be the policy of the Indiana State Medical Association that air travel costs incurred on business of the Association be reimbursed at tourist or economy rates, unless some physical ailment of the traveler makes this inadvisable for reasons of health or in cases of bona fide emergency trips when tourist accommodations are not available; and be it further

Resolved, That the Indiana delegation

to the American Medical Association be instructed to work for the adoption of a similar policy for travel costs by the American Medical Association.

Resolution No. 75-4

Introduced by: Vanderburgh County Medical Society

Subject: LOCATION AMA MEETINGS

Referred to:

Whereas, The American Medical Association has been espousing fiscal restraint for some time; and

Whereas, Drastic retrenchment of vital Association activities has recently been invoked; and

Whereas, Significant and sustained economies could be quickly achieved with enhanced efficiency for the Association merely by holding most meetings in Chicago where the headquarters and staff are already situated; therefore, be it

Resolved, That until such time as the Association's resources permit the luxury of travel and transportation of staff and equipment, all meetings be held in Chicago, except for government-related activities which may be better served by a Washington location; and be it further

Resolved, That scheduled sessions at distant sites be rescheduled for Chicago unless compelling and persuasive reasons can be advanced with appropriate fiscal data.

Resolution No. 75-5

Introduced by: Vigo County Medical Society

Subject: ISMA MEMBERS INSURANCE PLAN

Referred to:

Whereas, The cost of malpractice insurance has spiraled to a point where such insurance is beyond the reach of many physicians; and

Whereas, Many physicians are unable to purchase such insurance even at these unreasonable premiums; and

Whereas, Most physicians carry other insurance, such as life, fire, theft, car, personal liability, homeowners, etc.—all of which are profitable insurances for the insurance companies; and

Whereas, The insurance companies are unwilling to compensate the loss they may suffer from malpractice insurance with these highly profitable insurances; therefore, be it

Resolved, That the Indiana State Medical Association shall initiate an insurance program for all of its members which will permit its members to purchase all types of insurance through a self-insurance program of the Indiana State Medical Association.

Resolution No. 75-6

Introduced by: Commission on Aging
Subject: DEPARTMENT OF
GERONTOLOGY—I.U.
SCHOOL OF MEDICINE

Referred to:

Whereas, At the present time there is no department of gerontology at Indiana University School of Medicine; and

Whereas, There should be lectures in the freshman or sophomore year on the problems of the aged and aging; and

Whereas, There is a need for a clerkship in the junior year and/or an elective in the senior year in gerontology; and

Whereas, There is an added need for a residency in gerontology; and

Whereas, Externships in nursing homes for junior and senior medical students are of benefit to both the student and the nursing home; therefore, be it

Resolved, That medical students be exposed to gerontology through creation of the above; and, be it further

Resolved, That junior and senior medical students and/or interns or residents in gerontology and junior and senior dental students give regular physical and dental exams to nursing home residents.

Resolution No. 75-7

Introduced by: Ninth District Medical Society

Subject: TEL-MED

Referred to:

Whereas, Indiana State Medical Association's Tel-Med program has become its greatest and most successful public relations service; and

Whereas, An average of 800 tapes a day are requested and played; and

Whereas, Schools, church organizations and the general public at large have accepted and used this service; and

Whereas, No monetary funding to continue the program was provided by the House of Delegates; and

Whereas, \$25 per Indiana State Medical Association member would support the program for one year; therefore, be it

Resolved, That the Ninth District Medical Society requests that the Indiana State Medical Association dues be raised \$25; and, be it further

Resolved, That this money be used for Tel-Med service only.

Resolution No. 75-8

Introduced by: Ninth District Medical Society

Subject: MEDICAL MUSEUM

Referred to:

Whereas, The Medical Section of the Indiana State Historical Society is con-

verting the old Pathology Building at the Central State Hospital into a very fine and unique museum of Indiana medicine; and

Whereas, Indiana State Medical Association supported the start of this program with a grant; and

Whereas, No regular source of funding has been provided, now, therefore, be it

Resolved, That \$2.50 per Indiana State Medical Association member, per year, be used to support this project.

Resolution No. 75-9

Introduced by: Dubois County Medical Society

Subject: FEE INEQUALITY

Referred to:

Whereas, The government-reimbursed health care insurance systems in effect to date (Medicare and Medicaid) have, since their inception, utilized schedules of payments to physicians based on the concept of "usual and customary fees"; and

Whereas, It is felt by many that this latter concept has resulted in widespread and significant discrepancies in reimbursements to certain physicians when compared to their colleagues for rendering identical services to patients; and

Whereas, These aforementioned discrepancies in payment of physicians' fees are considered to be discriminatory on the part of the Federal Government and the state of Indiana against physicians in low-fee areas; and

Whereas, The refusal of federal agencies to publicize their schedules of "allowable charges" for physician fees is considered by many to be an effort to hide such possible discrimination; and

Whereas, The financial penalties which accrue to certain physicians by reason of the discriminatory fee payment schedules will be severely worsened to the extent that broader government-regulated health care insurance legislation is enacted utilizing similar fee payment schedules; and

Whereas, It is considered that if the present discriminatory manner of devising fee schedules is not changed and rendered equitable, medical care in certain rural communities could be further jeopardized because of problems with recruiting new physicians of high caliber; and

Whereas, Other problems and ramifications exist as a result of the federal government's present system of reimbursement, which are well known to most physicians but too numerous to list in this document; now, therefore, be it

Resolved, That the ISMA and all its officers and members use whatever means they find plausible or necessary—including law suits—to obtain from the present Medicare and Medicaid fiscal

intermediary (i.e. Indiana Blue Shield) a legible document USING NO CODES and showing the "allowable fees" for all areas in Indiana for the fifty (50) most common services for which physicians in this state are reimbursed by Medicare and Medicaid; and, be it further

Resolved, That a copy of said document be distributed to all members of the ISMA; and, be it further

Resolved, That the ISMA Board of Trustees study the said document along with appropriate representatives from the Department of Health, Education, and Welfare and make efforts to identify and assess the magnitude and implications of any fee discrepancies, and thereafter issue a policy statement to all members recommending possible means of correcting any discrepancies for areas of discrimination; and, be it further

Resolved, That a resolution (mutatis mutandis) encompassing the scope, intent, and purposes of the present resolution, be drafted by the ISMA delegation to the next AMA convention and that said delegation be directed to submit and work for the passage of said resolution by the AMA House of Delegates; and, be it further

Resolved, That the item "discussion and debate on discriminatory fee allowances by federal government" be contained on the agenda for the 1976 ISMA convention under unfinished business.

Resolution No. 75-10

Introduced by: Randolph County Medical Society

Subject: SECTION ON EMERGENCY MEDICINE

Referred to:

Whereas, Emergency medical care has become a predominant part of the medical care delivery system in Indiana and throughout the nation; and

Whereas, Increasing numbers of physicians are specializing in emergency medical care as their practice specialty; and

Whereas, The American Medical Association, cognizant of the import and critical need for physician input into developing local programs in emergency medical services, has an active Commission on Emergency Medical Service; and

Whereas, The Commission on Emergency Medical Service of the Indiana State Medical Association was the prime mover in developing legislation concerning emergency medical service in Indiana; and

Whereas, The American College of Emergency Physicians is also an active body on the national scene; now, therefore be it

Resolved, That the House of Delegates of the Indiana State Medical Association establish as an official section of the Association a Section on Emergency Medicine.

Resolution No. 75-11

Introduced by: The Marion County Medical Society
Subject: Recognition of Governor Bowen and General Assembly for Passage of HB 1460
Referred to:

Whereas, The General Assembly and the Governor of the State of Indiana have passed progressive legislation designed to aid in the alleviation of the medical profession's liability crisis in the state of Indiana; and

Whereas, The citizens of Indiana are best served by a working medical profession; and

Whereas, The members of the General Assembly of the State of Indiana acted in the best interest of the citizens they represent by fairly considering the factual information presented to them; therefore be it

Resolved, That the Indiana State Medical Association convey this expression of appreciation and respect to each member of the General Assembly and the Governor for their work in behalf of the citizens of the State of Indiana.

Resolution No. 75-12

Introduced by: The Marion County Medical Society
Subject: Creation of Section on Emergency Medicine
Referred to:

Whereas, Emergency medical care has become a predominant part of the medical care delivery system in Indiana and throughout the nation; and

Whereas, Increasing numbers of physicians are specializing in emergency medical care as their practice specialty; and

Whereas, The American Medical Association, cognizant of the import and critical need for physician input into developing local programs in emergency medical services, has an active Commission on Emergency Medical Service; and

Whereas, The Commission on Emergency Medical Service of the Indiana State Medical Association was the prime mover in developing legislation concerning emergency medical service in Indiana and

Whereas, The American College of Emergency Physicians is also an active body on the national scene; therefore be it

Resolved, That the House of Delegates of the Indiana State Medical Association establish as an official section of the Association a Section on Emergency Medicine.

Resolution No. 75-13

Introduced by: The Marion County Medical Society
Subject: Drug Substitution
Referred to:

Whereas, Some drugs with chemically identical active ingredients do not react the same way in the body, which can result in important therapeutic differences of drugs; and

Whereas, The physician must have ultimate responsibility and authority in drug product selection, since he has the fullest knowledge of the patient's needs and responses, with attendant objective to be held accountable for his selection of a particular drug product; and

Whereas, The American Medical Association has encouraged members of the Association to actively support state drug anti-substitution legislation; therefore be it

Resolved, That, The Indiana State Medical Association actively defend the concept of anti-substitution of drugs before the General Assembly of the State of Indiana.

Resolution No. 75-14

Introduced by: The Marion County Medical Society
Subject: AMA Policies on Medical Information to Lay Press
Referred to:

Whereas, Articles in lay publications meant to be informational to the public in general are increasingly being inappropriately applied by patients to their individual situations; and

Whereas, Physicians are increasingly placed in jeopardy by their patients who accept these broad presentations as personally applicable and contrary to their physician's treatment; and

Whereas, Publications and news releases of the American Medical Association are not distributed to members in advance of their wide distribution; and

Whereas, Publications and news releases of the American Medical Association have presented articles of this deleterious nature; therefore be it

Resolved, That the Indiana State Medical Association seek from the American Medical Association adoption of a publication policy which requires advance distribution of information to physicians which may be applied by members of the public without consultation of their physician or may imply inadequacy of treatment delivered in accord with convention.

Resolution No. 75-15

Introduced by: The Marion County Medical Society
Subject: Recognition of members for efforts toward passage of HB 1460
Referred to:

Whereas, The General Assembly and the Governor of the State of Indiana have passed aggressive legislation designed to aid in the alleviation of the medical professional liability crisis in Indiana; and

Whereas, Members of the Indiana State Medical Association provided leadership in identifying and communicating the factual information to the General Assembly; and

Whereas, The members of the General Assembly acted in the best interest of the citizens of the State of Indiana by considering the factual information presented to them; and

Whereas, These members of the Indiana State Medical Association endured personal hardship in behalf of their fellow physicians without expectation of recompense or recognition; therefore be it

Resolved, That this Association recognize Dr. William R. Cast, Dr. Anthony Lasich, Dr. Paul Muller, Dr. Gilbert Wilhelmus, and Dr. J. William Wright, Jr., and convey its deep appreciation by sending to each an inscribed copy of this resolution; and be it further

Resolved, That this recognition be preserved in time by causing this resolution to be published in THE JOURNAL of the Indiana State Medical Association.

Resolution No. 75-16

Introduced by: Board of Trustees
Subject: \$1.00 DUES INCREASE FOR AUXILIARY SUPPORT
Referred to:

Whereas, To assist the Indiana State Medical Association in its program for medical education, the Auxiliary with its many and varied projects raised \$50,037 for AMA-ERF, thus earning for Indiana a 1974 State Merit Award, placing 13th nationally in per capita contribution; and

Whereas, To assist the Indiana State Medical Association in its programs of medicine and public health the Auxiliary has promoted and assisted with programs for all ages beginning with prenatal clinics, well-baby clinics, immunization action month (IAM), day care centers, and selected child abuse and neglect (SCAN) for children, to youth organizations, camp for crippled children, and drug abuse for teenagers, to planned parenthood, blood pressure clinics, blood

bank and telephone hot line for adults, to nursing home visitation and Meals on Wheels for the elderly; and

Whereas, To assist the Indiana State Medical Association in a most important endeavor, this current year the Auxiliary promoted and participated in many legislatively oriented activities, such as writing letters, telephone committees, bus trips, coffees for legislators and people of the community, in addition to its annual Legislative Day which has been most successful in establishing rapport with our legislators; and

Whereas, To continue to assist the ISMA by uniting the wives of members, by coordinating and advising constituent auxiliaries, by expansion of area workshops, by sending delegates to educational meetings and by bringing educational programs and speakers to our state requires increasingly more funds; and

Whereas, The activities of the Woman's Auxiliary are beneficial to all members of the ISMA; now, therefore, be it

Resolved, That the House of Delegates replace the annual grant of \$1,000 to the Woman's Auxiliary with a \$1.00 increase in ISMA membership dues to be allocated annually to the Auxiliary for assistance in its programs.

Resolution No. 75-17

Introduced by: Board of Trustees
Subject: MEDICAL EXAMINER

Referred to:

Whereas, With this continued increase in crime; and

Whereas, In many instances law officials experience difficulty in determining a cause of death, as a suicide or a homicide; now, therefore, be it

Resolved, That the Association cause to be introduced in the 1976 General Assembly a bill to create a medical examiner system in the state of Indiana.

Resolution No. 75-18

Introduced by: Martin J. O'Neill, M.D.
Subject: M.D. ON SPECIAL EDUCATION ADVISORY COMMITTEE

Referred to:

Whereas, The Special Education Act of 1965 mandated the education of all handicapped children within the local community; and

Whereas, The handicapping afflictions are oftentimes multiple and require multiple disciplinary programs; and

Whereas, Such programs oftentimes have bearing on the child's physical well being; now, therefore, be it

Resolved, That the Indiana State Medical Association urges all agencies providing programs for the handicapped, including the State Department of Public Instruction, to seek consistent, appropriate medical input, hopefully in the form of a physician-member on the Special Education Advisory Committee at all levels.

Resolution No. 75-19

Introduced by: Lee Trachtenberg, M.D.
Subject: EXPANSION OF PARAMEDICAL SERVICES

Referred to:

Whereas, In some parts of the country there have been attempts by optometrists and other paramedical professionals to enlarge their respective areas of practice and responsibility to an extent unwarranted by their training and experience; and

Whereas, Such attempts, if successful, would pose a serious threat to the health and welfare of the general public; now, therefore, be it

Resolved, That the Indiana State Medical Association reaffirm that any legislation that would authorize non-physicians to engage in the diagnosis or treatment of disease or injury, or the diagnosis of the absence of disease or injury, is in conflict with the public interest; and be it further

Resolved, That the Indiana State Medical Association unequivocally opposes and seeks the defeat of any legislation that would extend the scope of any allied health profession into these areas of the practice of medicine.

Resolution No. 75-20

Introduced by: Lee Trachtenberg, M.D.
Subject: USE OF SUPPORT PERSONNEL

Referred to:

Whereas, The use of medical supportive personnel by physicians is necessary and desirable; and

Whereas, Physicians are legally responsible for the acts of persons in their employment; now, therefore, be it

Resolved, That the Indiana State Medical Association reaffirms that the health and welfare of the public requires that physicians' services be made more available to patients needing them by appropriate use of medical supportive personnel, and opposes any legislation which would prevent or prohibit the expansion

of the supply of needed medical care by this means; and be it further

Resolved, That the Indiana State Medical Association opposes unequivocally and with every resource legislative bills containing provisions which would prohibit or restrict physicians in any branch of medicine from using supportive personnel in any manner consistent with sound medical practice.

Resolution No. 75-21

Introduced by: Lee Trachtenberg, M.D.
Subject: MORATORIUM ON CREATION OF NEW LICENSING BODIES

Referred to:

Whereas, There is a continuing trend toward state licensing of professionals in paramedical fields such as nursing, optometry, dentistry, psychology, physical therapy, podiatry, pharmacy, audiology and chiropractic; and

Whereas, Licensure and self-regulating board status is being sought by professionals in other fields of paramedical practice; now, therefore, be it

Resolved, That the Indiana State Medical Association opposes legislation that would involve granting licensure and self-regulating board status (as opposed to mere certification) to any additional field of paramedical practice.

Resolution No. 75-22

Introduced by: Lee Trachtenberg, M.D.
Subject: EXCLUDING PHYSICIANS AS PRIMARY CARE PHYSICIANS

Referred to:

Whereas, Paramedical professionals in some fields are attempting to establish themselves as the sole source of providing primary care in their respective fields of practice at the point of entry into the medical care delivery system; and

Whereas, Such attempts, if successful, would make it difficult for persons needing physicians' services to obtain such services expeditiously; now, therefore, be it

Resolved, That the Indiana State Medical Association opposes legislation that would tend in any way to exclude physicians from providing primary care in any field of practice at the point of entry into the medical care system.

Resolution No. 75-23

Introduced by: Lee Trachtenberg, M.D.

Subject: LIMITATION OF
PARAMEDICAL
DUTIES

Referred to:

Whereas, There is an increasing tendency on the part of paramedical professionals in optometry and certain other fields to observe patients exhibiting obvious symptoms of pathology over an extended period of time and to subject such patients to prolonged therapy prior to referring them to a physician; and

Whereas, This has led to numerous incidents of blindness and other serious impairments that might have been avoided had such patients obtained prompt medical attention; now, therefore, be it

Resolved, That the Indiana State Medical Association supports legislation that would prohibit paramedical professionals from representing that they are qualified, or from holding themselves out to the public as being qualified, to diagnose the presence or absence of any disease or pathological condition; and be it further

Resolved, That the Indiana State Medical Association supports legislation that would require or encourage paramedical professionals promptly to refer patients to physicians when they detect the presence of the condition that may be pathological.

Resolution No. 75-24

Introduced by: Fort Wayne-Allen County Medical Society
Subject: PSRO POLICY — RE-
CONSIDERATION

Referred to:

Whereas, The House of Delegates of the Indiana State Medical Association has gone on record as opposing PSRO; and

Whereas, The above action has mandated that every official committee, commission and organ of the Indiana State Medical Association, including its Board of Trustees, cannot officially participate in any endeavor that concerns itself with PSRO; and

Whereas, There are organizations (i.e., Indiana Physicians Support Agency and the Indiana Statewide Professional Standards Review Council) already formed concerning themselves with PSRO activities and who have interested physicians on their boards but no official representation from organized medicine; now, therefore, be it

Resolved, That this House of Delegates of the Indiana State Medical Association reconsider its attitude toward PSRO in-

volvement so that ISMA may have input and some control over policy and activity which will vitally affect each of its practicing members.

Resolution No. 75-25

Introduced by: Fort Wayne-Allen County Medical Society
Subject: RESCIND RESOLU-
TION NO. 26

Referred to:

Whereas, Indiana Blue Cross-Blue Shield, by fiat, determines what constitutes usual and customary charges; and

Where, Fee profiles are then compiled on defined geographic areas, resulting in unrealistic profiles when applied to actual usual and customary fees in a particular area; and

Whereas, This results in a deterioration of physician-patient relationships when fees are disallowed; and

Whereas, This represents economic discrimination against patient and physician; now, therefore, be it

Resolved, The Indiana State Medical Association rescind Resolution 26.

Resolution No. 75-26

Introduced by: Fort Wayne-Allen County Medical Society
Subject: COLLECTIVE BAR-
GAINING

Referred to:

Whereas, Third party payers, i.e., governmental or private, now capriciously and arbitrarily exact controls over physicians through their payment mechanisms by the use of physician profiles, both individually and collectively; and

Whereas, Third party payers use sophisticated methods to determine these fee levels, such as the economic index, assignment of benefits, percentile applications, wage-price freeze and other such mechanisms, in equating and determining the value of physician service; and

Whereas, The American Medical Association has established a Department of Negotiations; now, therefore, be it

Resolved, That the Indiana State Medical Association retain legal counsel to assist in establishing a collective bargaining mechanism for negotiating with all third party payers.

Resolution No. 75-27

Introduced by: Fort Wayne-Allen County Medical Society

Subject: HONORARY MEM-
BERSHIP — MR.
LARRY L. PICKERING

Referred to:

Whereas, Larry L. Pickering has served with distinction as the executive director for the Fort Wayne-Allen County Medical Society for 14 years; and

Whereas, He has earned the respect and admiration of all members of the Fort Wayne-Allen County Medical Society and other physicians and other directors and or secretaries of other Medical Societies throughout the state of Indiana; and

Whereas, He has served as executive director of the Fort Wayne Medical Education Program, a part of the statewide medical education system; and

Whereas, His service as executive director has led to the development of outstanding community health care facilities, and because of his highly meritorious service which he has rendered the profession of medicine in Indiana; now, therefore, be it

Resolved, That this House of Delegates, in accordance with Article IV, Section 7, of the Constitution of the Indiana State Medical Association, unanimously elect Larry L. Pickering an honorary member of the Indiana State Medical Association.

Resolution No. 75-28

Introduced by: Fort Wayne-Allen County Medical Society
Subject: USE OF HEALTH IN-
SURANCE DOLLARS

Referred to:

Whereas, Indiana Blue Cross-Blue Shield has initiated an Indiana physicians survey in cooperation with Health Services Management, Inc., and various Indiana Health Planning Councils; and

Whereas, The survey was conducted without official consent of the Indiana State Medical Association and its component district and county medical societies; and

Whereas, This survey was alleged to have cost thousands of dollars to conduct; and

Whereas, This information could have been obtained at little or not cost through the Indiana State Medical Association and its component district and county medical societies; now, therefore, be it

Resolved, The Indiana State Medical Association make known to the citizens of Indiana and the Indiana Insurance Commissioner, its strong displeasure over this extravagant and wasteful use of health insurance dollars.

Scientific Exhibits

W. P. Loh, Ph.D., M.D.
Gary, Chairman

PROSPECTIVE PROBLEM ORIENTED MEDICINE

Exhibitor: Ronald G. Blankenbaker, M.D., Methodist Hospital, Indianapolis

Co-Exhibitors: Residents of Methodist Hospital Family Practice Residency Program

Attendants: Dr. Blankenbaker and Residents of the Family Practice Program

There is a time when the probability of developing a particular disease is minimal, i.e., the risk is zero. Next comes a period when the person is at risk of becoming diseased, followed by a time when the agent of disease is actually present. Subsequently, the patient develops signs which can be observed by the physician, symptoms which the patient himself observes, then disability and finally death. The only way to prevent the development of this disease is to catch the patient when he becomes "at risk"—long before he tips us off by signs of disease.

Prospective medicine, a term coined by Robbins and Hall,¹ is a new form of health care based upon this principle; it is (a) comprehensive in its concern for the individual's total risk, (b) continuous in its search for new risks, and (c) initiated before disease and injury, beginning with a quantitative estimate of the patient's own risks and a program of priorities for their reduction.² It organizes preventive medicine and health maintenance into an easily usable fashion for the busy practitioner.

This exhibit will show how this new concept of medical care can very readily be integrated into a simplified version of Weed's Problem Oriented Medical Record,³ how it can be adequately used in the busy physician's office, and how it may be computerized.

1. Robbins, Lewis C., M.D., Jack H. Hall, M.D., *How to Practice Prospective Medicine*, Methodist Hospital of Indiana, Indianapolis, 1970.
2. Hall, Jack H., M.D., Lewis C. Robbins, M.D., Norman B. Gesner, *Whose Health Problem? Postgraduate Medicine*, 51:114-120, January 1972.
3. Weed, Lawrence L., M.D., *Medical Records, Medical Education and Patient Care*, Year Book Medical Publishers, Chicago, 1971.

XEROGRAPHIC MAMMOGRAPHY—FINDINGS IN 2,000 CONSECUTIVE EXAMINATIONS

Exhibitor: George B. Pratt, M.D., and Robert E. Gerth, M.D., Radiology Department, Methodist Hospital, Indianapolis

Attendant: Robert E. Gerth, M.D.

The findings in 2,000 consecutive examinations at Methodist Hospital are reviewed with particular emphasis on the number of unsuspected carcinomas detected. As the starting date for this study, the operation on the President's wife was chosen, because this initiated a deluge of exams.

The exhibit will include the statistics of the series along with a display of the typical findings in benign conditions, artifacts and malignancy.

THE CHANGING CHARACTER OF BACTERIAL ENDOCARDITIS

Exhibitor: Edward L. Quinn, M.D., Henry Ford Hospital, Detroit

Co-Exhibitors: F. Cox, M.D., E. Fisher, M.D., T. Madhavan, M.D., K. Burch, M.D., Detroit

Attendant: Keith Burch, M.D., Detroit

In more than 300 cases of bacterial endocarditis seen at the Henry Ford Hospital since the introduction of penicillin, many changes in the etiology and treatment were observed. Presently, the causative organism is resistant in more than 60% of our cases (i.e.; staphylococcus, enterococcus, pseudomonas, and fungi), while in 1948 only 15% were of this resistant type. Factors responsible for this changing etiology include antibiotic resistant organisms, cardiac surgery with insertion of prosthetic devices, prolonged intravenous therapy and heroin addiction.

In the past 20 years alternate methods of administration of penicillin for the treatment of classical strep viridans endocarditis were used, and new alternate antibiotics were employed for the penicillin allergic patient. In addition, new potent antibiotics became available for endocarditis due to resistant organisms.

Medical improvements include cardiac

monitoring for arrhythmias and recognition of the "immune concept" of bacterial endocarditis as a cause of glomerular and other associated lesions.

The aim of the exhibit is to accentuate these medical changes in bacterial endocarditis through pictorial data from our series and to present current methods of specific antibiotic treatment by auditory means.

Despite all the advances in medical therapy, surgery played an increasingly important role. In recent years, surgery was required for 10-15% of patients with endocarditis, for treatment of active infection, treatment of residual valvular damage, treatment of mycotic aneurysms, etc. From our series, additional pictorial data will illustrate the surgical therapy.

THE DIAGNOSIS AND TREATMENT OF PRIMARY HYPERPARATHYROIDISM

Exhibitor: John Caras, M.D., Department of Medicine, Marion County General Hospital, Indianapolis

Co-Exhibitors: James Edmondson, M.D., C. Conrad Johnston, M.D., M. Rashid Akhairi, M.D., Department of Medicine, Indiana University Medical Center, and Norman Bell, M.D., Department of Medicine, Indianapolis V.A. Hospital

Attendants: John Caras, M.D.

James Edmondson, M.D.

With the widespread use of the SMA-12 autoanalyzer, many instances of hypercalcemia are being noted. Many of these are subsequently found to be due to primary hyperparathyroidism, thus making the occurrence of this entity much more common than was previously believed. Most cases of hypercalcemia are initially discovered by the patient's family practitioner or internist.

In recent years, important advances have been made in the diagnosis and treatment of this disease. Successful use has been made of many of these techniques of diagnosis and treatment here at IUMC, and this exhibit will demonstrate these advances as well as the clinical pres-

entation and physical findings associated with this disease.

1. Charts and posters will show the clinical presentation, age distribution, and laboratory and X-ray findings of primary hyperparathyroidism.
2. Standard as well as specialized roentgenological techniques will demonstrate the pertinent bony changes which take place in this disease.
3. There will be a visual display of band keratopathy as well as a display of the gross and microscopic characteristics of the various entities causing primary hyperparathyroidism.
4. Specialized, unique technic for the diagnosis and localization of parathyroid lesions will be illustrated. These include radioimmunoassay of parathyroid hormone, parathyroid angiography and selective sampling of blood from thyroid veins for parathyroid hormone assay.
5. Finally, the results of our accumulated surgical experience will be presented with regard to both pathology and patient outcomes.

THE EFFECT OF CORONARY ARTERY SURGERY ON SURVIVAL

Exhibitor: Cardiovascular Surgeons, Inc., Indianapolis

Co-Exhibitors: Harry M. Siderys, M.D., John Pittman, M.D., Gilbert Herod, M.D., and Harold Halbrook, M.D.

Exhibit to depict results of study on patients having severe coronary artery disease and having vein grafts (bypass) to the coronary arteries. The survival and results are compared with patients treated medically. Study is of more than 1,000 patients and covers a period of five years.

Comparisons will be shown on three 4 x 8 ft. panels using graphs, photographs and graphics.

OPTIMAL VISUALIZATION OF ESOPHAGEAL VARICES

Exhibitor: Roscoe E. Miller, M.D., Edward M. Cockerill, M.D., Stanley M. Chernish, M.D., Gordon C. McLaughlin, III, M.D., and Bruce E. Rodda, Ph.D., Indiana University Medical Center Indianapolis

Attendants: Drs. McLaughlin, Cockerill, Chernish and Miller

Following the parenteral administration of an anticholinergic drug, enlargement of varices during endoscopy has recently been reported. Can the radiographic appearance of distal esophageal varices be enhanced either by drugs, position, respiration, time or any combina-

tion thereof? This question prompted a double-blind crossover evaluation of placebo, propantheline bromide, and glucagon combined with various maneuvers.

Twelve patients with endoscopic proven varices volunteered for three examinations each. The results demonstrated (1) that an anticholinergic agent enhanced the appearance of varices in the distal esophagus, (2) that the effects of propantheline bromide are more diagnostic, but have greater side effects than glucagon or placebo, (3) that contrary to previous reports, positioning, time and respiratory cycle does influence visualization and identification of varices.

SURGICAL MANAGEMENT OF SPHINCTER INCONTINENCE

Exhibitor: Patrick F. Hagihara, M.D., Department of Surgery, University of Kentucky Medical Center, Lexington, Ky.

Co-Exhibitors: Ward O. Griffen, Jr., M.D., Department of Surgery, University of Kentucky Medical Center, Lexington, Ky.

Attendant: Patrick F. Hagihara, M.D.

This exhibit demonstrates various causes of anal incontinence, methods of surgical repair of anal incontinence due to injury to the anal sphincteric mechanism. Particular emphasis is placed on a procedure of repair which has been used in our cases. The results in our cases are also presented.

INDIANA FAMILY PRACTICE RESIDENCY PROGRAMS

Exhibitor: Indiana Family Practice Residency Programs, Indiana University Medical Center, Indianapolis

Attendants: Mrs. Cynthia H. Hopkins, Coordinator, and A. Alan Fischer, M.D., Indianapolis

The Family Practice Residency Program booth is designed to inform and educate the viewer as to what a Family Practice Residency is. An Indiana map locates each of the 10 residency programs in the state. A sample curriculum illustrates the three years of training the Resident receives while in the program.

The slide presentation introduces the directors of the programs, their residents and staff, and allows the viewer a glimpse into each Model Office Unit of the Residency Programs in the state.

PATELLAR PROBLEMS

Exhibitor: William B. Ferguson, M.D., Lafayette

Co-Exhibitor: Jack M. Gossard, M.D., Lafayette

Attendants: William B. Ferguson, M.D., and Jack M. Gossard, M.D., Lafayette

This exhibit will demonstrate some of the problems encountered with unstable patellas—subluxation and dislocation. Diagnostic aids and methods of treatment will be shown.

PHYSICIAN ASSISTANT PROGRAM

Exhibitor: Regenstrief Institute for Health Care, Indianapolis

Co-Exhibitor: Indiana University Department of Community Health Sciences, Indianapolis

The Regenstrief Institute and the Department of Community Health Sciences of the Indiana University School of Medicine, located on the grounds of the Marion County General Hospital, present "Helping in the Delivery of Health Care" for you, doctor.

AUGUST F. HOOK PHYSICAL REHABILITATION CENTER OF COMMUNITY HOSPITAL OF INDIANAPOLIS

Exhibitor: Community Hospital of Indianapolis, Indianapolis

Co-Exhibitors: Charles F. White, M.D., Indianapolis

Attendants: Nancy Drueley, and Bobbie Stone, Indianapolis

The August F. Hook Physical Rehabilitation Center display depicts the different modalities and hospital departments used in the rehabilitation of the physically disabled patient—Charles F. White, M.D., medical director.

COMMUNITY HOSPITAL REHABILITATION CENTER FOR PAIN

Exhibitor: Community Hospital of Indianapolis, Indianapolis

Co-Exhibitors: Karl Manders, M.D., John Marks, M.D., and Sue Collins, R.N., Indianapolis

Attendants: Sue Collins, R.N., and Elaine Lychins, Indianapolis

The Community Hospital of Indianapolis Rehabilitation Center for Pain display depicts the different modalities and hospital departments used in the rehabilitation of the chronic pain patient—Karl L. Manders, M.D., medical director.

HEMOGLOBIN VARIANTS MECHANISMS, MANIFESTATIONS, TESTING

Exhibitor: Doris H. Merritt, M.D.
Indiana University Medical Center

Co-exhibitors: Indianapolis Sickle Cell Center
Indiana State Board of Health

Attendants: Barbara Houston, R.N., Edward Hicks, Ph.D., Arthur Provisor, M.D., Robert Woodburn, M.D., and Doris H. Merritt, M.D.

This exhibit is designed to provide a compact continuing education package for the practicing physician on the mechanisms, manifestations and testing procedures related to the sickling hemoglobin variants. A five-minute closed circuit videotape on the molecular structure and properties of the red cell and the effects of sickle hemoglobin will be presented and can be operated by individual viewers. The mechanics and results of the latest hemoglobin analytic technics will be displayed along with information as to where and how physicians can obtain these analyses for their patients.

The program is supported by the United States Public Health Service, the Indiana State Board of Health and the Indianapolis Sickle Cell Anemia Center Foundation.

"Meet The Professor"
Monday, Oct. 20, 1975

The complete program for the series of "rap" conferences that has been arranged by the Department of Medicine of the Indiana University School of Medicine appears on page 820.

Each session will last one hour and will be limited to 15 persons. Each conference will be scheduled consecutively and will be repeated on a basis of requests received.

If you wish to participate in one or more of these sessions, please complete and return the form below to the ISMA at your earliest convenience.

Indiana State Medical Association
3935 N. Meridian St.
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"Meet The Professor"

I wish to make a reservation for—

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SCIENTIFIC EXHIBITS: W. P. Loh, Gary, chairman.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental

alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Both often



● Predominant psychoneurotic anxiety

● Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor

neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

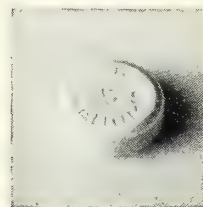
respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent

in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium[®]
(diazepam)
2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



IS OBESITY A "DISEASE"?

Unable to reduce her weight by the usual methods, Kay decided to try abdominal surgery. The surgery did help her weight problem. But it also led to a financial problem: was the cost of the operation covered by her group health insurance?

The insurance company refused to pay off, arguing that the policy covered only "diseases"—and that obesity was not a disease. However, in a court hearing, Kay de-

scribed half a dozen ways in which the excess weight had disrupted her bodily functions.

Impressed, the court granted her claim. The judge said that chronic obesity can be considered a disease because it "impairs health and shortens life."

If you have health insurance, the policy may use the word "disease" in defining your rights. As a rule the law takes a broad view of what that means, giving the policyholder the benefit of the doubt.

Still, not every abnormal condition will be included. In another case a woman sought insurance for the removal of four impacted wisdom teeth. But in a court hearing, it appeared that the teeth had been causing her no pain or discomfort whatsoever.

Rejecting her claim, the court

ruled that she had not been suffering from a "disease." The court said there had been "no disturbance in any of the functions of the body."

Of course, the policy itself may avoid doubt by spelling out the specific conditions to which it applies.

A man suffering from a severe abscess tried to collect health insurance on the ground that his policy listed "boils" as one of the covered ailments.

But the court said that boils, which are an external skin condition, are different from abscesses—which are internal. Turning down the man's claim, the court said: "The language of the policy is explicit."

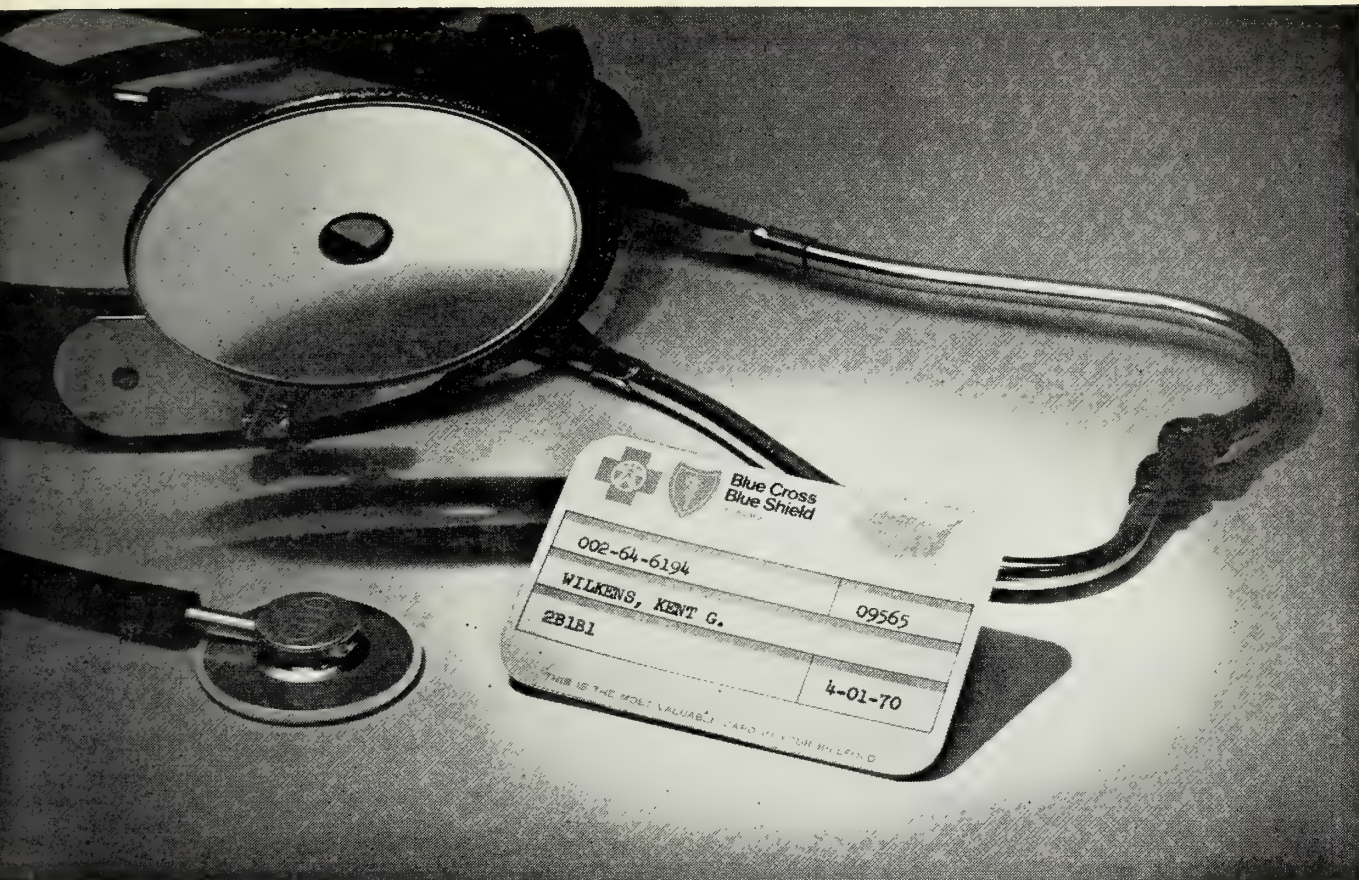
A public service feature of the American Bar Association and the Indiana State Bar Association. Written by Will Bernard.
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INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—August 1975

Disease	Aug. 1975	July 1975	June 1975	Aug. 1974	Aug. 1973
Animal Bites	1327	1151	1375	1251	1165
Chickenpox	48	57	240	69	22
Conjunctivitis	155	150	186	173	190
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	45	35	90	117	72
Gonorrhea	2050	1033	1082	1838	1250
Impetigo	315	143	98	182	227
Infectious Hepatitis	52	42	45	73	65
Infectious Mononucleosis	45	25	56	52	45
Influenza	1652	1133	1222	2933	1211
Measles					
Rubeola	33	14	13	14	7
Rubella	46	23	349	49	12
Meningococcic Meningitis	2	1	0	3	0
Meningitis, Other	6	6	5	7	2
Mumps	33	59	72	34	34
Pertussis (Whooping Cough)	23	9	12	10	3
Pneumonia	271	178	302	515	257
Poliomyelitis	0	0	0	0	0
Streptococcal Infection	862	584	888	1175	655
Syphilis					
Primary & Secondary	22	13	11	29	22
All Other Syphilis	143	125	119	122	116
Tinea Capitis	16	5	8	7	7
Tuberculosis (Active)	58	39	54	74	45

Take advantage of a great association!



Get these special benefits—available with your Medical Association membership

Expanded "people-planned" protection is now part of Blue Cross and Blue Shield coverage—and you're eligible! It's one more exclusive advantage of belonging to the Indiana State Medical Association—entitling you to special group rates for these benefits:

- One full year in-hospital care
- 100% semi-private room and hospital extras
- Allowances for surgery, anesthesia, obstetrics, medical visits, diagnostic and radiation therapy
- PLUS Major Medical Benefits

That's not all. You also benefit from the immediate recognition and automatic acceptance of the Blue Cross and Blue Shield membership card. The special rates available through the Indiana State Medical Association membership make this coverage your best investment in personal protection. You can get it—now.

Call or write: Miss Marilyn McCallip, Professional Accounts, Blue Cross and Blue Shield of Indiana, 120 W. Market Street, Indianapolis, Indiana 46204. Telephone: (317) 263-4925.

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EDITORIAL AND ADVERTISING INFORMATION

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Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

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Natural balance doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

Found useful in the management of vertigo* associated with seas affecting the vestibular system.

Can relieve nausea and vomiting often associated with vertigo.*

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Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG 

A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert[®]/25 (meclizine HCl) 25 mg. Tablets for vertigo*

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association



The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

Opinion
&
Dialogue

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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For long-term control of hypertension*

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

*

WARNING

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium fre-

quently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy

patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

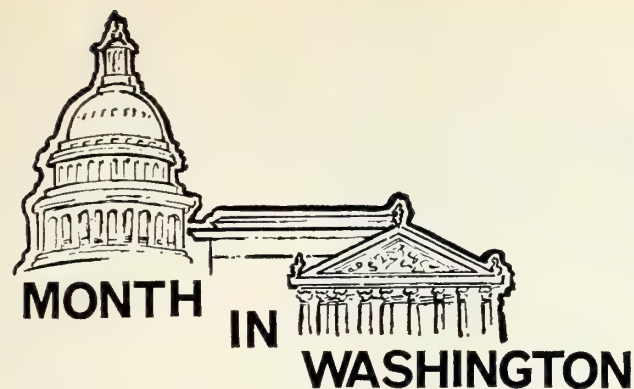
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This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

CONGRESS DESERTED WASHINGTON for a summer holiday, leaving behind not only the August heat of the Potomac swamplands but also most of its planned health legislation still hanging up in the humid air.

With passage of national health insurance (NHI) written off for this year, both the Senate and House on return will tackle a variety of health or health-related matters, including health manpower, already passed by the House, amendments to the Health Maintenance Organizations Act (HMO) and possible changes to the Medicare law.

While the health subcommittee of the House Ways and Means Committee has scheduled public hearings on NHI for Oct. 28, subcommittee chairman Daniel D. Rostenkowski (D-Ill.) stated "the considerable lead time needed to forge a NHI bill" as the unexpected reason for hearings this year.

Pressing problems with Medicare, however, have prompted Rep. Rostenkowski to schedule hearings on possible changes to that law on Sept. 19.

"Recent oversight hearings concerned certain HEW regulations, including those on utilization review and the 8½ % nursing care differential. As we consider Medicare changes, I expect that we will explore the possibility of major modifications in the way hospitals are reimbursed. And we will look at how Medicare may help hospitals facing steep increases in malpractice insurance rates," Rep. Rostenkowski said.

The slating of an additional hearing indicates the subcommittee will probably draft legislation to change some of the present Medicare regulations. There may not be time for final Congressional action this year, but legislation could clear Congress next year.

Many of the revisions the subcommittee members are considering would be welcome to the medical profession.

Listed as one topic of the hearing was the present law's requirement that physicians' Medicare reimbursement be tied to a type of cost-of-living index and geared to the 75th percentile of normal and customary charges. The AMA has challenged the fairness of HEW's proposed index and warned that the regulation could drive increasing numbers of physicians away from assignment. Another hearing subject is "physicians' services

reimbursement—possible basic changes in present 'reasonable charge' system."

Two other controversial Medicare regulations are up for review—possible revisions in Professional Standards Review Organizations (PSRO) provisions, and utilization review requirements for hospitals, the latter under temporary injunction by the federal courts as a result of an AMA court protest.

Other issues to be considered by the subcommittee:

- Termination of the 8½ % nursing differential in hospital costs;

- Redefinition of reasonable cost level for hospitals (90th to 80th percentile and revised hospital classification system);

- Nurse staffing requirements in rural hospitals (authority to waive certain requirements with respect to nurse staffing requirements in rural hospitals expires on Jan. 1, 1976).

- Medicare relationship to Federal Employee Health Program (no payment may be made under Medicare, beginning Jan. 1, 1976, for services provided to members of the Federal Employee Plan unless a system of coordination between two programs is developed under present law).

- Revisions in hemodialysis and kidney transplant provision to improve administration and enhance cost effectiveness.

- Revisions in home health care provisions.

- Medicare Part B premium increase provision—correction of technical error in present law which precludes increasing the premiums.

- Institutional services reimbursement—possible basic changes from the present retroactive reasonable cost reimbursement.

- Consideration of a specific proposal, with respect to malpractice, to permit hospitals to self-insure and charge such costs to Medicare.

- Revisions in current coverage of ambulance services.

- Coverage of pap smears under Medicare Part B.

- Possible changes in payment methods for physicians' services when patient is deceased.

Continued on page 876

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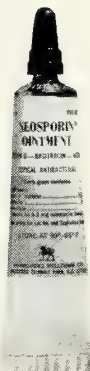
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Similar hearings will get underway in the Senate this fall. The Senate Finance Subcommittee on Health, according to Chairman Herman Talmadge (D-Ga.), plans sessions "to resolve some of the reimbursement and related problems in Medicare and Medicaid, and some of the more arbitrary and inequitable regulations which have been promulgated by HEW."

A BILL RELAXING SOME OF THE FEDERAL requirements for Health Maintenance Organizations (HMOs) to receive federal aid has been approved by the Health Subcommittee of the House Commerce Committee. The legislation was spurred by the lagging start of the once-vaunted HMO program which has been stalled despite high hopes of backers it would prove popular and become a viable alternative to regular health insurance and fee-for-service.

No full committee action was taken prior to the August recess. Senate committee consideration won't begin until after House action, putting a time squeeze on the bill as far as final action this year is concerned.

The AMA had urged the House Commerce Subcommittee headed by Rep. Paul Rogers (D-Fla.) not to reduce the present HMO program to a subsidy for prepaid group practice plans.

The Subcommittee bill amended the controversial "dual option" clause in the law that requires employers to give individual workers their choice between an HMO plan and private health insurance. Labor has protested this interferes with collective bargaining. The amendment gives union representatives the right to veto an HMO option, but not to veto a regular health insurance option. Thus, Labor would have power to block an HMO but not to accept one for all employers at the exclusion of fee-for-service health insurance.

The provision averted the danger that labor unions could force all employees in a company to accept a union-formed and/or-controlled HMO.

Another important action was elimination of the present "open enrollment" provision for HMOs, a provision designed to avoid having HMOs able to skim the cream and take only low-risk groups or individuals. However, the subcommittee bill retains present requirements that HMOs, to qualify for aid, must "enroll persons who are broadly representative of the various age, social and income groups within the area it serves. . . ."

The bill allows HMOs to offer as optional rather than mandatory some HMO services and to limit the preventive health services which would have to be offered as basic services.

ANOTHER BLOW TO THE BELLY HAS BEEN DELIVERED to national health insurance plans relying on Social Security financing. The General Accounting Office, supervisor of federal spending and operations for Congress, reports Social Security's trust funds

"face exhaustion in the near future because of increased benefit levels due to inflation, and high unemployment causing reduced contributions. . . ."

According to GAO, projections covering the next 75 years show that the system will also incur a large long-range deficit because of the decreasing birth rate and the rising cost of living.

In order to alleviate the situation, GAO pointed out, Congress will have to approve some of the remedies already suggested by various advisory bodies, including financing of Medicare Part A out of general revenues, the equivalent of adding a new \$9 billion annual spending program. The money saved for Social Security, \$9 billion, would be used to support other Social Security programs, primarily the main retirement disability program. Social Security taxes would not be changed, but federal corporate and income levies presumably would have to furnish an extra \$9 billion.

Unless such steps are taken, General Accounting warned, "there may be no alternative to increasing (Social Security) taxes" or the wage base or both.

A FEDERAL COURT RULING THREATENS to crimp the Food and Drug Administration's plan to make it easier for "generic drug" makers to market their products quickly after patent protection runs out on brand-names.

An order by U.S. District Court Judge June Green in Washington, D.C., blocked FDA from allowing Zenith Laboratories, Inc., Northvale, N.J., to market a generic version of chlorthalidopoxide without first obtaining a new drug application. The ruling was sought by Hoffman-La Roche Inc., Nutley, N.J., which markets the product as Librium.


Judge Green said the NDA requirement for generic drugs has an anti-competitive effect, but "the overriding interest in insuring the health and safety of the public through compliance . . . requires the result reached here."

Securing an NDA for a product is a lengthy and expensive procedure, requiring test data, etc., and would delay for a long period introduction of competitive "generic" drugs in cases where patents have lapsed.

If upheld by higher courts, the ruling could hurt the HEW Department's controversial Maximum Allowable Cost (MAC) program intended to foster purchase of generic drugs by Medicaid patients. MAC has been challenged in Federal Court by the AMA.

THE FOOD AND DRUG ADMINISTRATION HEARD strong arguments for and against warning labels for oral diabetic drugs at an unusual one-day hearing on one of the Agency's keenest medical-scientific controversies over the past five years.

Continued on page 879



Putting out the fires of arthritic pain

Rheumatoid arthritis can sometimes spread like wildfire, with joint after joint going up inflamed. The usual onset is manifested by spotty joint involvement but an acute onset of symmetrical polyarthritis may be noted.^{1,2*}

If aspirin fails, consider Butazolidin alka. Giving one capsule four times a day often provides prompt, pain-relieving, anti-inflammatory action to help restore joint mobility. The results you can get within a week can be maintained on as little as one or two capsules daily.

Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions. For full details, please read the prescribing information. It's summarized on the back of this page.

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If it doesn't work in a week, forget it.



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Ragan C. The Clinical Picture of Rheumatoid
Arthritis in Arthritis ed 8 edited by J L
Hollander and D J McCarty Jr Philadelphia
Lea & Febiger 1972 chap 21 p 335

Geigy

Important Note This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of fever, sore throat, oral lesions (symptoms of blood dyscrasia), dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.

Contraindications Children 14 years or less, senile patients, history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy, blood dyscrasias, renal, hepatic or cardiac dysfunction, hypertension, thyroid disease, systemic edema, stomatitis and salivary gland enlargement due to the drug polymyalgia rheumatica and temporal arteritis patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpre-

dictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals. Careful detailed history for disease being treated and detection of earliest signs of adverse reactions, complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug, its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dys-

pepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy, CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia, ulcerative stomatitis, salivary gland enlargement.

(B)98-146-070-J (10/71)

For complete details, including dosage, please see full prescribing information

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A new British study and the testimony of one of the original American investigators cast some doubt on the validity of the scientific data FDA has been relying upon in its effort to crack down on oral hypoglycemics. On the other hand, one of Ralph Nader's health teams contended the warning label was insufficient and called for written consent by patients taking the oral products.

The hearing was called to further air the differences of opinion on the FDA's proposed warning that there may be increased risk of cardiovascular death in diabetic patients treated with the oral drugs. The proposal is based on a 1961-1970 clinical study by the University Group Diabetes Program (UGDP) which claimed that heart disease death rate was twice as high among patients treated with the oral drugs compared with those on insulin or on special diets.

A double blind study by University of London professor Harry Keen suggested evidence of long-term benefits from Tolbutamine and Phenoformin and no

long-term cardiovascular toxicity. An FDA official said this latest study, carried out over an eight-year period, will require close consideration.

The UGDP study may have been prejudiced by a conflict of interests on the part of one of the investigators, a researcher in the study testified.

Angela Bowen, M.D., Olympia, Wash., told the FDA "It would be on mighty thin ice" if it goes forward with its plan to require warning labels without first investigating whether the study was valid.

Describing herself as a "very reluctant witness," Dr. Bowen told the investigation took on almost a vendetta approach where Tolbutamide was involved. In addition, she said some of the deaths ascribed to that drug appeared to have been caused by factors unrelated to the diabetic conditions of the patients.

J. Richard Crout, M.D., Director of the FDA's Bureau of Drugs, said he found the allegations "a little astounding" and would have to evaluate them. ◀

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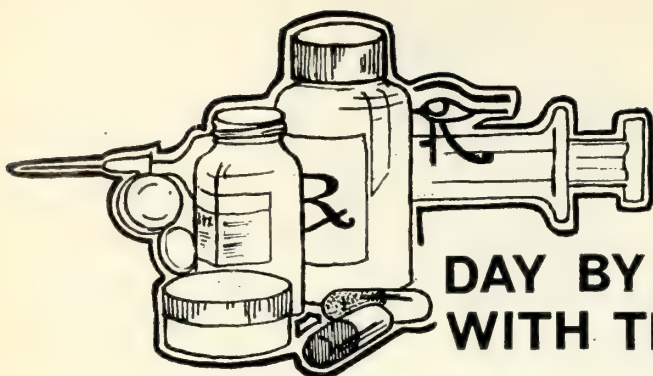
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DAY BY DAY WITH THE F.D.A.

Food warehouses deserve the highest sanitation standards. Inspection and achievement of compliance are duties of the FDA. Some 60% of the nation's food warehouses were out of compliance in 1971. In 1974, however, only 14% were insanitary. Further improvement is a continuing program with educational programs, criminal citations, fines and imprisonment as found necessary. It's a big job—140 million tons of food are distributed in the U.S. each year.

* * *

Candy pacifiers labeled "Not for Infants" have been recalled from the market on the reasoning that infants can't read and could be harmed by the gadgets.

* * *

An entire shipment of English Harvest dinnerware was returned to Canada because the salad plates leached out 88.4 parts per million of lead. Seven PPM is the upper tolerable amount.

* * *

Damaged high intensity mercury vapor discharge lamps will emit enough ultraviolet rays to produce photokeratitis and skin erythema. Such bulbs wear an outer envelope. Instructions are that when this envelope is broken the bulb must be discarded. FDA is working with schools on this problem.

* * *

Molding sand is treated with motor oil and methyl alcohol. It is reddish and resembles a dehydrated tomato product called tomato extender. Imagine the results when molding sand was packed in tomato extender drums without changing

labels, thereafter to be delivered to a school kitchen. FDA calls it a serious labeling mistake. Luckily someone took a small taste of the food before serving.

* * *

Grains and beans are treated with a preservative which is toxic to humans and helps preserve the grain and beans for use as seed. The prepared seed is usually sold in stores which also sell grain for animal feed. The Oregon agricultural inspectors have found that some citizens have been buying grain for human consumption from the seed and animal feed stores, and in the process some of them have accidentally mixed mercury-treated seed grains in their diet.

* * *

A U.S. marshal recently seized 14 cases of 1-pint packages of a product "skin-cote waterless hand cleaner" packed in containers labeled with "pure lard" or "soft margarine," and topped with a lid which stated "ice milk." The charge was misbranding. Natch!

* * *

It has been estimated that as many as 280,000 cases of salmonellosis each year in the U.S. are turtle-associated. The FDA, for this reason, has banned commercial distribution and sales of pet baby turtles and turtle eggs. Shippers have, in the past two years, been required to certify that their turtles were Salmonella-free, but this failed to contain the danger.

* * *

The FDA has a new method of analysis. High-speed chromatog-

raphy is a method of separating mixtures into their constituents by absorption into a solid. A weight reducer which was recommended by its seller for rubbing into the skin was found to be composed of two substances, meta- and paramethyl hydroxybenzoate, neither of which has any effect on weight. After the analysis the FDA separated the phony medicine and its promoter—no mention about absorbing the promoter into a solid.

* * *

Six million pounds of flour, cornmeal, rice and similar foods stored in Puerto Rico was found to be infested. The embargoed items are either destroyed or converted to animal feed, depending on the magnitude of infestation.

* * *

The president of a warehouse in Chicago was found guilty of criminal contempt of court for refusing to permit completion of an inspection of his warehouse pursuant to a properly issued warrant. He was incarcerated and the inspection was completed. Certain lots of dates were found contaminated with maggots and the basil was full of rodent and insect contamination.

* * *

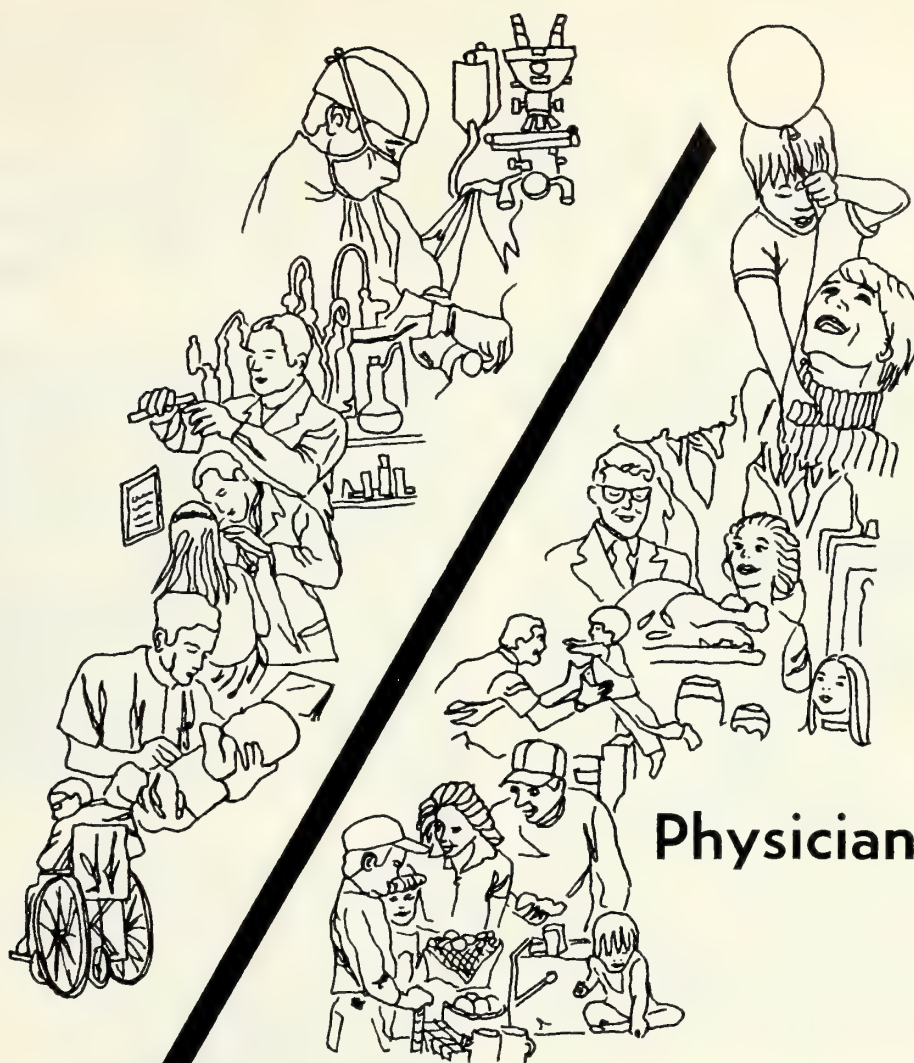
Imitation flavored syrups are being found on the market that are sweetened with saccharin, while the label says sugar.

* * *

Wheat, three truckloads of it, valued at \$48,000 was seized because the trucks, which had been previously carrying ammonium phosphate pellet fertilizer had not been cleaned properly.

* * *

A large piece of blue ice fell thru the roof of a house near the Denver Airport. It turns out that it had formed on a high-flying airliner when the toilet leaked and had fallen off when the liner descended through warm air to land. The FDA has advised airlines to improve the service to aircraft waste systems. Reminds you of the old saw—"It's a good thing cows don't fly." ◀



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Practical Clinical Psychopharmacology: The Tranquilizers

ROBERT E. SNODGRASS, M.D.
Indianapolis

Introduction

THE introduction of the tranquilizers into the practice of medicine has caused a dramatic positive change in the treatment of the psychiatric patient. The tranquilizers have brought about changes which are in many ways comparable to the spectacular treatment results which the antibiotics have brought into medicine.

Years ago it was not unusual for a young patient to die of acute primary pneumonia. Acute osteomyelitis progressing to death was not uncommonly seen. Thanks to the antibiotics, death due to these diseases is practically unheard of nowadays. Similarly, only 20 years ago it was not unusual for a patient to suffer an acute psychotic breakdown and to have to go to a state mental hospital and spend the remainder of his life there. There was once a common belief among laymen that if a person lost his mind it was an irretrievable loss. And, at times, there was some truth to this belief.

Back in 1953, between my sophomore and junior years of medical

school, I was employed as an extern at Madison State Hospital in southern Indiana. It was there that I met my wife, who was working as a psychiatric nurse. I would never go through her ward, which often had many violently agitated male patients present, without asking her to accompany me. I was fearful that one of her patients might become agitated and harm me in some fashion. I returned there a few years later after the tranquilizers had become available and found that most of the patients had either gone home or had markedly improved.

The discussion of the various tranquilizer drugs covered in this paper is based upon my experience as a general practitioner of medicine from 1956 through 1964 and as a psychiatrist in private practice since 1967. There are a number of psychotropic drugs available, but the drugs discussed in this paper are the drugs which I find most useful in my own practice. It is of importance to the practicing physician, regardless of his specialty, that he be familiar with several of the fundamental psychotropic drugs and know how to use them well, just as he is familiar with certain types of insulin and digitalis.

Major or Antipsychotic Tranquilizers (The Neuroleptics)

RAUWOLFIA DERIVATIVES

The history behind the tranquilizers is fascinating. For over a thousand years the drug *Rauwolfia serpentina* had been used in India for treating various maladies such as nervousness and high blood pressure. It was discovered that when reserpine, a *Rauwolfia* derivative, was given to patients who had hypertension and also nervous problems the nervousness often improved or disappeared. For a while, back in 1954 and 1955, reserpine was used quite extensively here in Indiana for treatment of emotional disorders.

We now rarely use reserpine in psychiatry, since we have many drugs which are far superior. In fact, paradoxically, we have now found that reserpine may cause depression by depleting the brain of catecholamines, especially norepinephrine, at the significant adrenergic receptor sites of the brain. This has led us to postulate a biological basis for depression—the catecholamine hypothesis. This has been a most exciting event in psychiatry.

Reserpine is still used in medical

Dr. Snodgrass is Clinical Assistant Professor of Psychiatry, Indiana University Medical Center, Indianapolis.

practice in treating hypertension, so we must be on the lookout for depression developing in our patients who are taking this drug. This is of importance in view of the fact that depression causes suffering and, at times, may lead to suicide.

PHENOTHIAZINES

Thorazine

A French drug company, Rhone Poulenc, observed that phenothiazine, a drug in use as a vermifuge, exhibited some interesting properties. Some molecules were changed on the phenothiazine structure, and a phenothiazine drug derivative called chlorpromazine was produced and studied in France. The drug showed two unusual properties. It was found to control nausea and vomiting and also showed an amazing ability to block conditioned responses without impairing normal reflexes. It was found that rats, when placed in a box whose floor was a metal grid, naturally would jump up a wooden pole in the center when an electrical stimulus was applied to the grid. By repeatedly sending electrical shocks through the bottom of the cage and ringing a bell at the same time, these animals could be conditioned in the classical Pavlovian manner to jump when only the bell was rung and no current was sent through the bottom of the cage. The drug researchers discovered that when these same laboratory animals were given chlorpromazine, they would jump when the electrical stimulus was applied and the bell was rung, but when the bell was rung and no electrical stimulus was applied, they would not jump.

The rights to study and manufacture chlorpromazine were given in 1952 to the Smith Kline & French Laboratories here in the United States. The United States investigators, too, were intrigued with the drug's unusual properties. Within a short time it was discovered that patients who had delusions or who were hallucinating often stopped hallucinating, and their delusions often disappeared or became less annoying to them. It didn't take the

clinical investigators long to realize that we had our first antipsychotic drug. This drug was introduced into clinical medicine in the United States as Thorazine. It has become established as a fundamental drug in psychiatry.

Thorazine is useful in treating many psychotic disorders. I find it of particular value in treating the assaultive, agitated, paranoid patient. It also is of value in treating the manic or hypomanic patient and has been useful in controlling the agitation seen in involutional melancholia. It also is of value in treating patients who suffer from a psychosis associated with an organic brain syndrome, such as a psychosis due to cerebral arteriosclerosis. The beginning dosage of Thorazine is usually 25 mg q.i.d. This may be increased as needed up to a maximum dose of 1 to 2 gm per day.

Thorazine has some undesirable side effects of which every physician should be aware. Thorazine may cause postural hypotension. Patients may complain that they feel light-headed, especially when they get up suddenly. Also, housewives may complain of feeling that they are going to faint if they suddenly bend over in their kitchen to get a pot or pan out of a low cabinet. Thorazine may cause severe hypotension if given parenterally, and we should be on the lookout for this as a side effect. It should not be given to a patient suspected of having a myocardial infarction for fear that it may cause hypotension, which could then possibly extend the infarction.

The antiemetic effects of Thorazine may mask the nausea and vomiting so often seen in an acute surgical abdomen. Therefore, the physician should keep this in mind when he is examining a patient who has been taking Thorazine and who complains of abdominal pain.

Thorazine may produce in patients a marked photosensitivity. Patients who have been started on this drug should be warned to be on the watch when they get out into the bright sunlight, or they may suffer a severe sunburn.

Thorazine may also cause opacities to develop in the lens of the eye.

Females taking Thorazine may complain of milk developing in their breast and also show false positive pregnancy tests. These side effects are seen with some of the other phenothiazines also. The reason for this is that the tranquilizers work on the deep structures of the brain—the limbic and reticular activating systems. Evidence suggests now that phenothiazines alter dopamine metabolism.

Thorazine may lower the seizure threshold in a patient. It is not uncommon for a patient who has been started on Thorazine to experience a sudden grand mal seizure. Patients who do have this first seizure should not be written off as simply having had the seizure because they were taking Thorazine; rather, they should have a complete neurological work-up to rule out other problems such as intracranial aneurysm or brain tumor. Epilepsy, however, is not a contraindication for the use of Thorazine.

At times, too, Thorazine may cause jaundice. This seems to be unrelated to the dosage. The basic pathology in the jaundice consists of obstruction brought about by changes in the biliary duct cells. The actual liver parenchymal cells are not damaged. One should get into the habit, when making ward rounds, of looking at the sclerae of patients who are taking Thorazine, to ascertain if jaundice is present. If the patient does appear jaundiced, the color of his urine and stool should be inquired about. If the answer is positive, then a serum bilirubin should be obtained, and the urine should immediately be checked for bile. The patient should be taken off the Thorazine at once, of course. Once again, the jaundice should not be attributed solely to the Thorazine; rather, a complete medical work-up should be done to rule out a silent stone in the common bile duct or a tumor of the head of the pancreas.

Thorazine may also cause agran-

ulocytosis. This is a condition which is usually seen more often in the elderly Caucasian female. Patients, therefore, should be warned to report to us the persistence of any unusual sore throat, fever or swollen glands in the neck.

Thorazine and other antipsychotic drugs also may produce a most distressing set of neurological symptoms. The patient may develop an acute parkinsonian-like syndrome, or he may develop various dystonias such as opisthotonus, an oculogyric crisis, peculiar motions of the extremities and spasm of the masseter muscles. Or the patient may experience akathisia, which is a form of extreme motor restlessness. Patients who experience this syndrome should be given 50 mg of Benadryl diluted with five or ten cc of normal saline or sterile water slowly intravenously. The Thorazine should then either be reduced, or a drug such as Cogentin 0.5 mg q.i.d. or Artane 2 mg q.i.d. added to the patient's drug regime. The acute neuromuscular reaction may also be antidoted with intramuscular Cogentin or Artane. Many psychiatrists prefer to place patients who are taking Thorazine in a dosage of higher than 200 mg daily on prophylactic Cogentin or Artane. Others prefer to wait and see if the patient will develop neuromuscular symptoms. This is somewhat controversial.

A rather uncommon side effect of prolonged use of Thorazine and other phenothiazines and certain other antipsychotic medications is tardive dyskinesia. This syndrome is characterized by involuntary movements of the tongue, face, mouth or jaw. We may see the patient periodically protruding his tongue, or puffing his cheeks or puckering his mouth and showing all sorts of unusual chewing movements. Involuntary movement of the extremities may also occur. There is no known treatment for tardive dyskinesia at this time. The antiparkinsonism agents do not stop the symptoms of tardive dyskinesia. We must make a choice between two evils. If the patient is in desperate need of the antipsychotic drug, then

we must weigh this need against the drug's side effects. The use of the lowest possible dosage of the antipsychotic agent which is adequate to control the symptoms seems to be one answer. Another approach could be trying the patient on a different type of antipsychotic drug if he develops findings of tardive dyskinesia.

Stelazine

In the late 1950s the drug researchers changed some molecules once again in the basic phenothiazine structure and introduced onto the market another phenothiazine, Stelazine. Stelazine was originally introduced for treating anxiety. It is of value in treating the patient who comes in complaining of feeling extremely tense and anxious and in whom a mental status examination clearly shows that many problems of everyday living exist in the patient causing her to worry. For example, the patient may be concerned about a teenage daughter who is dating and petting too heavily with her boy friend, and also be worried about the fact that her husband has been drinking alcohol to excess and is in danger of losing his job. These persons are often helped by being able to talk out their problems, and their anxiety may be lessened by the addition of Stelazine in a dosage of 1 to 2 mg b.i.d. to q.i.d. to their treatment program.

Incidentally, a proper psychological evaluation to help elucidate and point out to the patient the stress points in his life which are causing him to experience emotional symptomatology is of extreme importance.

Stelazine was not around very long until it was discovered that it had a potent antipsychotic effect when it was given in larger doses. Thus, our second major fundamental drug was introduced into clinical psychiatry. The antipsychotic dosage is usually 5 to 10 b.i.d. to q.i.d.

All these phenothiazines have anticholinergic side effects. However, Stelazine has fewer distressing side effects and seems to be best for the

withdrawn, listless, depressed, psychotic patient. With it we should be on the lookout for neuromuscular reactions and realize that it may lower the seizure threshold in the patient.

We will sometimes see patients who do not respond to Stelazine or Thorazine alone but who improve when either drug is added to their drug regime. That is to say, they do better taking both drugs. There is no rhyme or reason for this. The two drugs, in a sense, seem to work psychically synergistically.

Mellaril

In the late 1950s a third potent antipsychotic drug was introduced into clinical psychiatry. Mellaril was initially introduced in a similar fashion to Stelazine for the treatment of anxiety. The anti-anxiety dosage of Mellaril is 10 to 25 mg b.i.d. to q.i.d. It, too, was not around long until it was found that in higher dosages it worked beautifully as an antipsychotic. Mellaril does not seem to lower the seizure threshold or cause neuromuscular reactions quite as commonly as do Thorazine and Stelazine. Mellaril should never be used in a dosage higher than 800 mg daily. There is a danger that it will cause retinopathy leading to serious visual difficulties.

Mellaril possesses an interesting side effect. All of the tranquilizer drugs tend to decrease the sexual libido. Mellaril frequently retards orgasm in the male, and at the time of ejaculation there may be no secretion of seminal fluid. It is of value, then, in treating a patient who suffers from premature ejaculation. Frequently seen in family practice is the young male who comes in complaining in the early days of his marriage that he ejaculates prematurely. He may often be treated satisfactorily with reassurance and Mellaril in a dosage of 10 to 25 mg q.i.d. for a few weeks. Then, after the patient regains his composure and skill, the Mellaril may be gradually reduced and finally withdrawn altogether.

The above drugs are broken down into a further sub-classification. They are: the aliphatics, of which

Thorazine, Sparine and Vesprin are representative; the piperidines, of which Mellaril, Quide and Serentil are representative; and the piperazines, including Stelazine, Trilafon, Compazine, Permitil and others.

The importance of knowing about the above classifications is that if the patient is not doing well on a drug which belongs in the piperidine sub-classification, then he probably will not do well if you start him on another drug that belongs within the same sub-group. You would be wise to switch to a drug in a different sub-group.

BUTYROPHENONES

Haldol

Another group of major tranquilizers or antipsychotics is known to us now—the butyrophenones. Of this group Haldol is the outstanding one. Haldol is usually used in a dosage of 0.5 mg to 5 mg q.i.d. for treatment of the schizophrenic who has failed to respond to the phenothiazines. It is of value, too, in treating the agitated patient who suffers from a psychosis associated with cerebral arteriosclerosis and the manic phase of manic-depressive illness.

Haldol is the drug of choice for treatment of Gilles de la Tourette's syndrome. This syndrome is characterized by multiple grimacing, tics, restlessness and the uttering of obscenities. Evidence strongly suggests that this disease is due to faulty dopamine metabolism in the brain. This, then, is another neuropsychiatric disorder for which evidence is accumulating to lead us to postulate a biological basis for certain types of mental illness.

The major side effect of Haldol is that it may cause intense neuromuscular reactions. I have seen patients on Haldol experience so much restlessness that I have been led to believe for a time that their problem was due to extreme anxiety. We must not make this error, for this may lead us to increase the dosage of the drug when we should instead add Artane or Cogentin to the patient's drug regime. This restlessness, as stated earlier in this paper,

DRUGS

Generic Name	U.S. Trade Name
Benztropine methanesulphanate	Cogentin
Chlordiazepoxide	Librium
Chlorpromazine	Thorazine
Chlorprothixine	Taractan
Clorazepate	Tranxene
Diphenhydramine	Benadryl
Fluphenazine	Permitil, Prolixin
Haloperidol	Haldol
Hydroxyzine	Atarax, Vistaril
Mephenesin	Tolserol
Meprobamate	Equanil, Miltown
Mesoridazine	Serentil
Oxazepam	Serax
Perphenazine	Trilafon
Phenaglycodol	Ultrán
Piperacetazine	Quide
Prochlorperazine	Compazine
Promazine	Sparine
Reserpine	Rau-Sed, Reserpoid, Sandril, Serpasil
Thioridazine	Mellaril
Thiothixene	Navane
Trifluoperazine	Stelazine
Triflupromazine	Vesprin
Trihexyphenidyl	Artane

may also be caused by the other major tranquilizers.

THIOXANTHENES

Navane and Taractan

The thioxanthenes constitute another group of the major or antipsychotic tranquilizers. Representatives of this class which are used here in the United States are Taractan and Navane. Navane seems to work particularly well in the depressed schizophrenic who has not responded to the phenothiazines. Navane is also of value in treating neurotic depression. These drugs, too, may cause intense neuromuscular reactions.

Minor or Antianxiety Tranquilizers

Miltown or Equanil

The history behind the minor tranquilizers is also of great interest. It was noted that the muscle relaxant, mephenesin or Tolserol, exhibited some calming properties in patients. Therefore, molecules were changed,

and a chemically related drug, meprobamate, was introduced into clinical medicine back in the mid 1950s. Meprobamate, which is known by its trade names of Equanil and Miltown, has been of great value in treating anxiety. The usual dosage is 400 mg q.i.d. However, patients may become severely dependent on meprobamate. At times, we will see patients who find it difficult to adjust to the rigors of mature adult living and who find that four meprobamate tablets make them feel good and that eight make them feel better and sixteen even better. These patients often meet with unexpected accidents and end up in the hospital and may develop withdrawal seizures after they have been hospitalized for three to five days and deprived of the drug.

Librium

Librium was introduced into clinical medicine in the early 1960s. It has rapidly become a fundamental drug in psychiatry and is of extreme value in treating anxiety. It is usually prescribed in a dosage of 10 mg q.i.d., though it is also available in 5 and 25 mg capsule and tablet strengths. Librium is also available in a parenteral form and is one of the safest tranquilizer drugs known to mankind. It is of particular value in calming the tense, anxious patient. It can be used with safety in a patient with other medical problems. For example, Librium is of value as an adjunct in calming anxiety in a patient who has had a myocardial infarction or who is awaiting surgery. Though drug dependence and withdrawal seizures have been reported with this drug, in my experience it has been a very safe one, and I have not observed these complications.

Valium

Valium was introduced in the 1960s for treatment of anxiety. It is available in a dosage of 2, 5 and 10 mg tablets. The 5 mg strength is the most popular form and is given q.i.d. Valium is also valuable as a muscle relaxant, making it useful in treating patients with a sore neck due to a whiplash injury, and

also is of value in treating a patient suffering from sciatica due to herniated intervertebral disc disease. Valium is helpful in treating spastic torticollis. Valium also is of great value as an adjunct in treating convulsive disorders. It is of particular value in treating status epilepticus, and it is available in a parenteral form.

Other minor tranquilizers are Serax, Vistaril, Ultram and Tranxene, Tranxene has not been available to the private practitioner very long; therefore, an opportunity for careful evaluation of it has not yet been afforded the clinician.

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532 Turtle Creek, North Drive,
Suite A-1
Indianapolis 46227

From THE JOURNAL 50 Years Ago

The advent of the proctoscope and the Roentgen ray have aided materially in a definite preoperative diagnosis of cancer of the sigmoid. The early symptoms of malignancy of the sigmoid, however, are so indefinite that it is not until late in the progress of the disease that the physician or the patient is awakened to the fact that the pathological process is in the colon. In a good many instances, the symptoms of cancer in this location may be regarded so lightly by the patient that the physician's diagnosis of cancer quite often fails to convince the sufferer of the seriousness of his malady. It is for this reason that, in spite of the vigorous educational propaganda waged throughout the United States for an early diagnosis of malignancy, cancer of the sigmoid is rarely discovered in its incipency.

An analysis of numerous statistics shows that about 36% of the cases of malignancy of the colon occur in the sigmoid. Next to cancer of the rectum, it is the most frequently encountered cancer of the large intestine (Ewings). . . .

At the Mayo Clinic, from Jan. 2, 1915, to December 1922, of 359 cases of cancer of the colon, 71 were of the cecum, 44 of the ascending colon, 28 of the hepatic flexure, 50 of the transverse colon, 23 of the descending colon, and 104 of the sigmoid flexure. . . .

Great care must be taken in interpreting colon radiographs as apparent filling defects occur from various causes and erroneous conclusion are not infrequent. . . .

Palliative operations, usually a colostomy, have been done upon cases which were considered inoperable, either before or after the time of the operation, the colostomy having been done for the relief of obstruction or to prolong life. By sidetracking the intestinal contents, the tumor is retarded in its growth and considerable comfort and prolongation of life is to be had. . . . "Cancer of the Sigmoid," James Y. Welborn, M.D., Evansville, *JISMA*, October 1925.

Informed Consent for Surgical Operation

J. NEILL GARBER, M.D.
Indianapolis

THE consent form outlined below is the record form by which the patient is informed concerning the operative risks and by which he indicates his understanding and consent. The facts in the form are, of course, supplemented and reinforced by answering the questions of the patient or his responsible relative.

The form as represented here is given or mailed to the patient and, when completed, is returned by the patient prior to admission to the hospital.

Consent For Surgery and Release of Liability of the Doctors and the Hospital Staff

We have made arrangements for
..... to enter
(Name of Patient)
the
Hospital on
(Day) (Date)
for the surgical operation planned
for
(Day) (Date)

The operation proposed for you,
your wife, son or daughter
(Name)
..... is

I. This operation will be done under general anesthesia which means that you, the patient, will be put to sleep by a fully qualified, capable anesthetist so recognized by his colleagues in the same specialty and by the hospital.

Rarely, unpredictable complications occur while a patient is under the anesthetic, such as:

A) Clots or hemorrhage in the

brain which may cause paralysis, speech defects or other nerve system disability. This complication does not occur often and there is no way to tell beforehand that it might occur.

B) Cardiac arrest or stopping of the heartbeat which could produce damage to the brain or death. Here again, the chance of this complication cannot be known before the operation. Many patients having advanced heart disease require surgery, even upon the heart itself, and go through the operation without any heart complications. Every effort will be made to lower the possibility of such complications by evaluation of your general condition beforehand. All known means for resuscitation (rescue) are available for instant use in the operating room.

C) Aspiration of food or other foreign materials such as teeth, etc. Every precaution is taken by the anesthesiologist before the operation to make certain that the stomach is empty and that conditions within the mouth are safe for anesthesia.

D) Occasionally, a spinal anesthetic or block anesthetic is given to produce temporary loss of pain sensation and paralysis in the lower extremities (spinal) or in one extremity such as an arm (block). Here again, there is the remote possibility of nerve damage.

II. As in all surgical procedures, there are other elements of risk.

A) Wound infection, which may necessitate several subsequent operations and produce severe crippling.

B) Blood clots and/or drop-

lets of fat which may go to the heart, lungs or brain and which can result in death or severe damage to these organs. This complication may occur at any time after the operation as thrombophlebitis (clotting usually in leg veins) causing pain and tenderness or as silent clots moving in the blood stream which are known to be present only when they cause symptoms by lodging in the lungs or other organs.

C) Unusual or abnormal response to blood transfusion. Every effort is made by repeated checking to be certain that the proper blood is used. Blood transfusion is used as sparingly as possible and only when absolutely needed. The patient must be aware that complications such as hepatitis can occur despite every precaution.

D) Pneumonia.

E) Infection in the urinary tract; that is, kidneys and bladder.

III. *Special Operations Where Applicable, such as Total Hip and Total Knee Replacement or Other Joint Replacement.*

A) The hazard of infection in these operations is greater and may even require total removal of the artificial joint. This cement (poly-methyl-methacrylate) has been approved by the Food and Drug Administration. The patient may develop a "foreign body" response to the materials of the new joint so that this artificial joint may have to be removed or replaced.

B) The artificial joint may wear out and require replacement.

C) The artificial joint may not relieve all joint pain and such

pain may be as bad or even worse than before surgery.

If the artificial joint has to be removed from the hip, the result is that of an unstable or very loose hip joint which may be painful and which shortens the leg about two inches.

If the artificial knee joint has to be removed, one hopes to get a healed wound with a totally stiff painless knee. This is the best alternate result from this condition.

NOTE: "Bone cement" (polymethyl-methacrylate) is a plastic which has been used extensively in Europe for many years by dentists, neurosurgeons and orthopaedic surgeons without any known adverse effects. Its usefulness in holding hip and other joint prostheses (artificial joints) in place has been reported in many articles in medical literature. It may conceivably produce toxic disturbances in any or all tissues of the body (blood, brain, lungs, heart, kidneys, etc.), which could be harmful. Just how harmful is unknown. Experience in Europe indicates that it is safe to use in bonding metal and plastic hip joint components to human bones.

It is impossible for any physician or surgeon to guarantee or assure either by direct or implied statement, spoken or written, that a satisfactory end result will follow any surgical operation.

At the same time, you may be assured that every effort will be made to give you the best possible treatment and to get the best possible result in every way.

Close cooperation between your family physician and the surgeon during your hospital care and care afterwards is most desirable.

Careful observation will be maintained to detect signs of those complications I have described, and appropriate treatment will be instituted if any occur.

Please list all medicines and dosage, particularly aspirin and blood thinners, you are taking on a regular basis.

This consent for surgery and the release from all liability therefrom is to apprise the patient of all presently known complications from the surgical operation he is advised to have.

In full view of the preceding, I request that Dr. of the Hospital, (city & state)

perform upon me the proposed operation described or perform any additional procedures that his judgment may dictate during the course of, or subsequent to, the aforesaid operation or procedure.

In consideration of the performance upon me of such surgery, and as inducement therefor, I hereby release, discharge and acquit the Board of Trustees, its officers, agents and employees, and each of them, including but not limited to the professional personnel involved in the surgery, from any and all liability to me or anyone claiming by, through or under me, for injury or death sustained by me arising out of, occurring in connection with or

in any way related to the performance of such surgery and any expected or unexplained risks thereof. I further agree that this release shall be binding upon me and upon my heirs, legatees or devisees, executors, administrators and assigns.¹

Please read this letter carefully, initial each page and sign below with an adult witness and return to this office before your admission to the hospital.

If you have any questions in regard to this information supplied here or do not understand this letter, please list your questions in writing and return.

Signed this day of 197..

NAME
(Patient or person authorized to consent for patient)

ADDRESS

CITY AND STATE

ADULT WITNESS TO PATIENT'S

SIGNATURE

RELATIONSHIP TO PATIENT .

.....

ADDRESS

CITY AND STATE

Signed: Dr.

BIBLIOGRAPHY

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5626 East 16th St.
Indianapolis 46218

INDIANA MEDICAL BUREAU

1010 East 86th St.—72 Winterton
Indianapolis 46240
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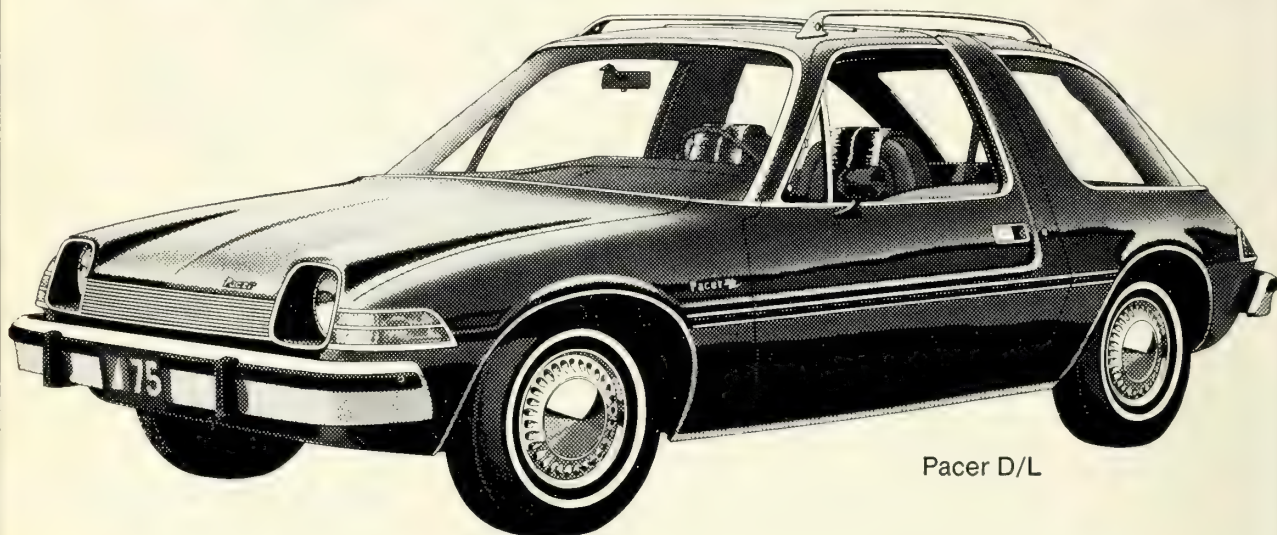
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Children Treated With Radiation

Doctors who treated children with radiation between the late 1930s and early 60s for head and neck abnormalities should *contact those patients for a physical exam of the neck and a thyroid scan*. Hospitals should also recall those patients.

Radiation was once deemed medically safe to shrink tonsils, adenoids and the thymus gland. Although it has been stopped for 15 years, recent evidence shows a higher risk of benign or malignant thyroid growths among people irradiated.

Thyroid cancer is related to the amount of radiation and age at the time of treatment, according to incidence data.

Compared to other cancers, thyroid is uncommon, grows slowly, rarely spreads and has a *high cure rate keyed to early detection* with a thyroid scan and neck exam.

Mammography—A Word of Caution

Mammography is being used increasingly as a method of screening women for early signs of breast cancer. A panel of experts from the American College of Radiology, however, recently recommended to the FDA Medical Radiation Advisory Committee against routine screening of asymptomatic women under the age of 35. The panel further stated that the efficacy of routine mammogram examinations for asymptomatic women in the 35-50 age range is still in question and that additional studies should be devoted to this area. A demonstration study-project for mass breast cancer screening of women in 27 centers throughout the country is currently being supported by the National Cancer Institute and American Cancer Society.

Technics and radiographic equipment used for mammography are unique, and care should be taken to comply with minimum safety requirements. The procedure requires

low energy radiation (e.g., 25-40 kVp) with low filtration in conjunction with appropriate films. Special equipment is available; but when conventional x-ray equipment is used, means should be provided to ensure that the tube is not at higher potentials and inadequately filtered, but is in accordance with recommendations of the International Commission on Radiological Protection in 1969.

A Subcommittee on Mammography of the Medical Radiation Advisory Committee has been appointed to consider in depth the radiological health aspects of the procedure, so that patients will receive maximum diagnostic benefit with minimum radiation exposure. FDA's Bureau of Radiological Health will consider the recommendations of the Subcommittee for potential action programs.

NEW LITERATURE AVAILABLE

The Differential Radiologic Diagnosis of Bone Tumors—

this new 20-page Professional Education Publication presents broad aspects of radiologic bone tumor diagnosis. X-ray appearance is described and principles for evaluating potential malignancy are included in the text. Twenty-four representative films are reproduced to illustrate both benign and malignant bone tumors. This publication is a separate reprint of an article by Raymond L. Osborne which appeared in the July/August 1974 issue of *A Cancer Journal for Clinicians*.

Cancer of the Gastrointestinal Tract, Part One (Esophagus, Stomach, Small Intestine)—this 74-page reprint of articles covering cancer of the gastrointestinal tract is the newest addition to the continuing series on Current Concepts in Cancer, appearing in the *Journal of the Amer-*

CANCER

CORNER



New information from
Indiana Division
American Cancer Society, Inc.
2702 East 55th Place
Indianapolis 46220

ican Medical Association. It contains 26 short, authoritative articles under five general headings: (a) Esophagus: Detection and Diagnosis; (b) Esophagus: Treatment—Localized and Advanced; (c) Gastric Cancer Diagnosis; (d) Gastric Cancer: Treatment Principles; and (e) Small Intestine; Diagnosis and Treatment. Also included are illustrations and tables. Introduction and comments are by Dr. Philip Rubin. Reprints of Part Two will be made available soon after the series in *JAMA* is concluded.

SMOKING TIPS FOR PATIENTS

If I want to quit smoking, shall I see my physician?

Yes. It is realized that the smoking problem is the patient's problem; however, physicians can be supportive to the patient's effort. The physician may in some cases prescribe medication, and/or suggest a diet which will prevent one from gaining too much weight.

Physicians as a profession have been leaders in acting on the risks of cigarette smoking: the Public Health Service estimates that 100,000 physicians (half of the physicians who once were cigarette smokers) have kicked the habit. A California study in 1967 showed that only 21.3% of all physicians in the state were cigarette smokers. WILLIAM M. DUGAN, JR., M.D. Chairman of Professional Education Indiana Division American Cancer Society, Inc.

The Woman's Auxiliary Reports to ISMA



Dear Doctors:

As in the past, October is a very busy month. Governor Otis R. Bowen, M.D., has issued a Proclamation proclaiming the month of October 1975, as Immunization Action Month in Indiana. He urges our citizens to join this observance both by insuring that their own children are fully immunized, and by encouraging the efforts of physicians and public health officials to protect the health of the community as a whole through immunization.

The American Medical Association Auxiliary has suggested a variety of ways for us to implement this important activity, including publicizing it in our state newsletter. The following are project suggestions:

1. Supply volunteers where needed to help with immunizations, record taking, etc.
2. Offer assistance to doctors and nurses in checking immunization records, making reminder calls to parents, etc.
3. Work through schools, day care centers, and other public facilities to educate parents to the need for immunization.
4. Ask the local mayor to proclaim IAM 1975 to publicize the month.
5. Enlist the aid of local radio and TV stations, requesting them to run spots to show what immunizations are needed, how often, and other pertinent information.

This year the National Auxiliary has arranged a completely new format for the Annual Fall Meeting. The 1975 Leadership Confluence is scheduled Oct. 13-15, 1975, at the Drake Hotel, Chicago. Indiana is invited to send nine county presidents-elect. It is the intention of the Board of Directors to provide state and county leaders with new dimensions of leadership skills. Each state participant has an opportunity to register for five seminars. The subjects to be discussed include: child abuse, communications at the county level, emergency medical services, health education—curriculum in the schools, the impaired physician, legislative update, membership—county emphasis, rape, safety on the streets, and services to the aging.

Exhibit space will be available for each state to display material that will be of interest to other states.

Last, but certainly not least, it is time to focus on the ISMA Convention Oct. 20-22, 1975 at French Lick. I would like to take this opportunity to invite each of your wives to attend the Auxiliary's open board meeting, luncheon and afternoon cardio-pulmonary resuscitation demonstration. The scene of activity will be at the French Lick Sheraton Oct. 20, 1975. Features of the Board Meeting will include an opportunity to receive first-hand information from officers and chairmen. The luncheon will facilitate discussions with the various State Committee Chairmen.

If you live in a county that has no organized Medical Auxiliary, your wife can become a member-at-large. She will receive publications and information from State and National that will keep her informed about concerns of medicine.

May this be a very successful year for all.

Sincerely,

A handwritten signature in cursive script that reads "Allie C. Reed".

Mrs. Edsel S. Reed
President
Indiana State Medical Auxiliary

NEW increased limits under ISMA sponsored income protection plan

33 $\frac{1}{3}$ % more in fact! You can now provide yourself monthly income disability protection up to \$2,000 from the previous limit of \$1,500 (subject to a participation of \$3,500 per month with other companies) if you are disabled and unable to work due to an accident or illness.

4 OTHER INSURANCE PLANS AVAILABLE

In addition to this disability income protection that now helps you replace more of your earned income when you cannot work, there are four other Association sponsored supplemental insurance plans. You, as an ISMA member physician or professional corporation are eligible to add to your protection through these supplemental plans.

- **EXCESS MAJOR MEDICAL PLAN** provides coverage after your present plan is exhausted. Up to \$250,000 coverage and two deductibles available (\$15,000 or \$25,000). Unlimited surgical schedule and includes extended care and nursing home benefit.
- **OVERHEAD EXPENSE PLAN** provides needed dollars to help you pay off overhead expenses (employees' salaries, rent, utilities, property taxes, etc.) in the event of your disability. When disability strikes—your business overhead expenses keep right on going—even when you can't.
- **CASH VALUE LIFE INSURANCE PLAN** provides permanent life insurance protection up to \$50,000 for those currently insured under the ISMA term plan. Accumulates attractive cash values. At age 65, policy becomes 50% paid-up with no further premium payments. All premiums returned in event of your death before age 65.
- **FAMILY LIFE INSURANCE PLAN** provides benefits up to \$60,000 in the event of your death.

ALL PLANS ARE ALSO AVAILABLE FOR PROFESSIONAL CORPORATIONS

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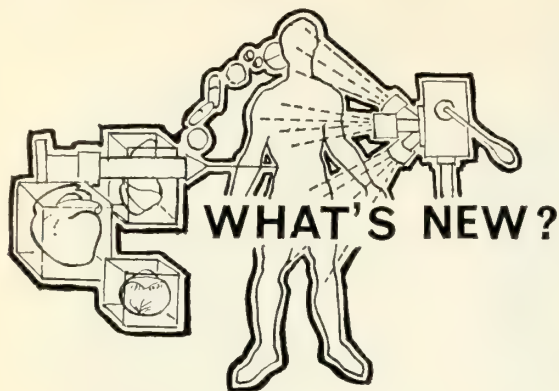
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Riker is introducing BUFTM Kit for Acne, a non-prescription item available in drugstores. The kit contains a BUF-PUF[®] nonmedicated Cleansing Sponge and a BUFTM Acne Cleansing Bar, packaged with a booklet on skin care and a plastic holding tray. The Cleansing Bar is soap-free and contains mild drying agents to encourage the drying and peeling actions found effective in managing acne.

* * *

Merck Sharp & Dome Orthopedics has adapted their LIGHTCAST II Casting System to the making of lightweight splints. Splint tape, similar to cast tape, but with a closer weave and smoother finish, may be molded to the limb and then cured by an auxiliary lamp in three minutes. The material is available in kit form.

* * *

Wyeth Laboratories introduces a Cardiobeeper[®] System for remote heart monitoring. The monitor weighs only 5 ounces, fits into a shirt pocket or purse, and may be used to transmit heart or implanted pacemaker signals to a doctor over any conventional phone. It is powered by a standard transistor radio battery.

* * *

Orthopedic Equipment of Bourbon has an exclusive, new WESTFIELD SHOULDER IMMOBLIZER designed to provide secure, effective immobilization of the shoulder and to apply controlled tension to the acromioclavicular area.

* * *

Boehringer Ingelheim is introducing Alupent[®] Syrup (metaproterenol sulfate), 10 mg/5 ml. It is a single-entity bronchodilator for bronchial asthma or reversible bronchospasm. This is a new dosage form in addition to the tablets and aerosol.

* * *

Ames announces an especially labeled 2-Drop CLINITEST which offers the diabetic patient a simple procedure which measures sugar from zero to 5%. The new method requires and is sold with a special color chart which differs from the original color chart.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdose or individual hypersensitivity, reactions similar to those after meperidine or morphine overdose may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline[®] (nalorphine HCl) or Narcan[®] (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdose; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: **Lomotil is contraindicated in children less than 2 years old.** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdose may cause severe, even fatal, respiratory depression. Signs of overdose include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

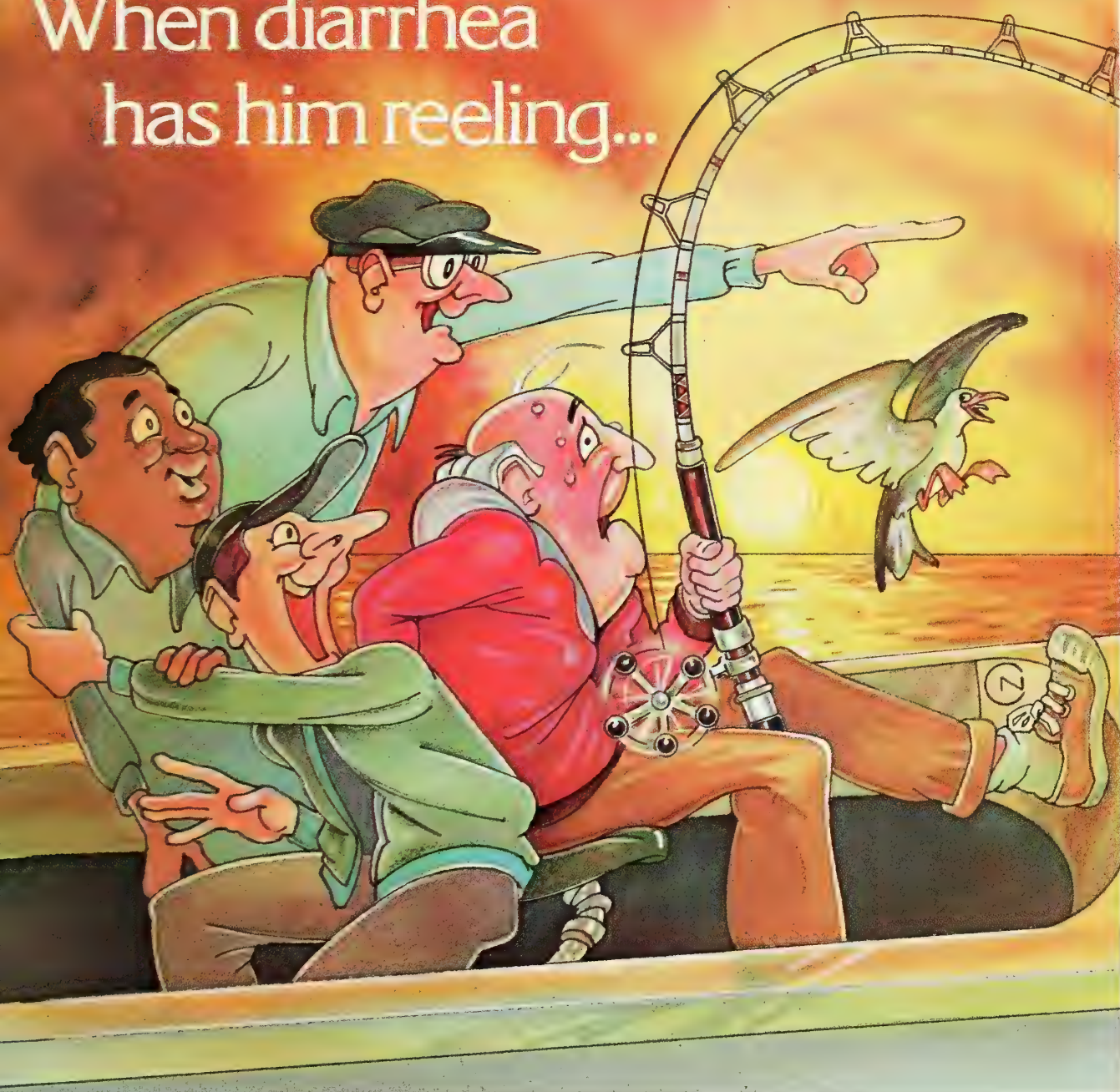
SEARLE

Searle & Co.
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co.
Medical Department, Box 5110,
Chicago, Illinois 60680

455

When diarrhea
has him reeling...



Diarrhea can hook anyone. When it does, physicians and patients both want prompt control of diarrheal symptoms. Lomotil will usually control diarrhea promptly.

This rapid action can halt the emergency aspect of diarrhea and is comforting and reassuring to the patient. Electrolyte and

fluid losses can be corrected while the specific cause of the diarrhea is being determined. If an infective agent is the cause, appropriate specific therapy should be given along with Lomotil.

Lomotil is contraindicated in children less than 2 years old.

Lomotil[®] TABLETS LIQUID
holds the line.

Each tablet and each 5 ml. of liquid contain: diphenoxylate hydrochloride 2.5 mg. (Warning: May be habit forming), atropine sulfate 0.025 mg

In hypertension,

ALDOMET[®] (METHYLDOPA | MSD)
usually offers more
than effective lowering
of blood pressure...

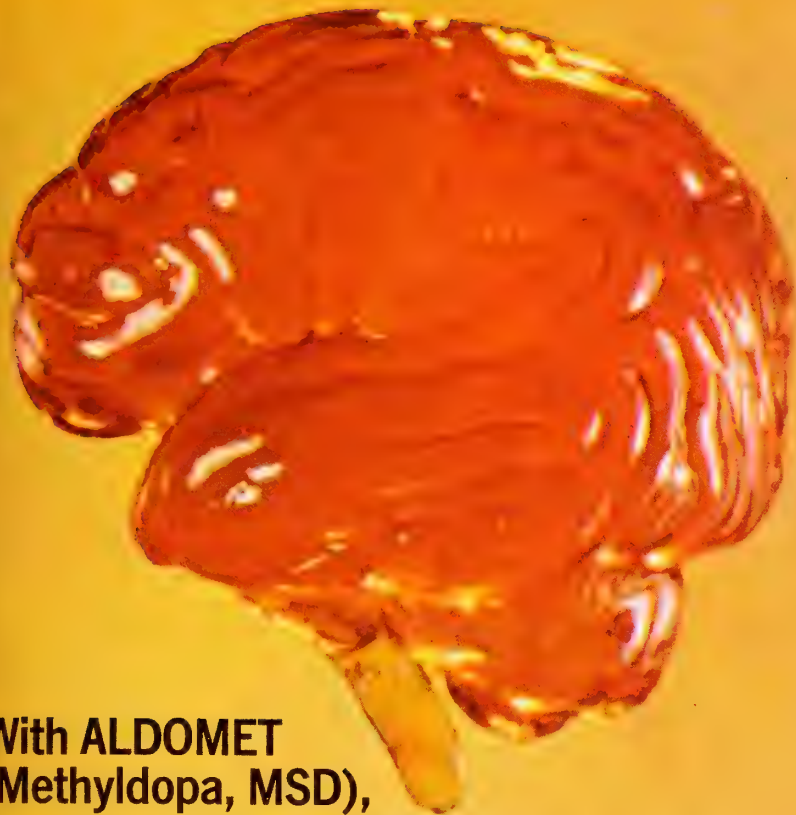


**With ALDOMET
(Methyldopa, MSD),
existing renal function
is usually unchanged**

ALDOMET has no direct effect on renal function. When used in effective doses, ALDOMET usually does not reduce glomerular filtration rate, renal blood flow, or filtration fraction.

**With ALDOMET
(Methyldopa, MSD),
cardiac output is
generally unchanged**

ALDOMET has no direct effect on cardiac function. When ALDOMET is used in effective doses cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is slowed.



**With ALDOMET
(Methyldopa, MSD),
symptomatic postural
hypotension is infrequent**

ALDOMET reduces both supine and standing blood pressure. Less frequent symptomatic postural hypotension is experienced with ALDOMET than with many other antihypertensive agents. Exercise hypotension and diurnal blood pressure variations rarely occur.

for hypertension

TABLETS, 250 mg, 500 mg, and 125 mg

**ALDOMET®
(METHYLDOPA|MSD)**

a unique antihypertensive agent

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders. It is not recommended in pheochromocytoma. It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

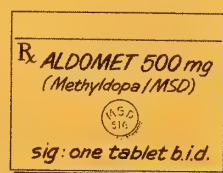
to further
simplify therapy
for many patients

now available
ALDOMET® 500 mg
(METHYLDOPA|MSD)

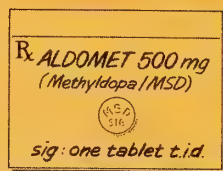
- often more practical to prescribe
- easier for patients to remember

Now offered in addition to the standard 250-mg tablet, the new ALDOMET 500 mg tablet is a patient convenience. An especially important one, since in hypertension convenience of the dosage schedule is one factor that can make the difference in compliance of the patient. The minimum daily dose of ALDOMET is 250 mg b.i.d. The usual starting dose is 250 mg t.i.d. Dosage is adjusted as necessary by adding or deleting 250 mg or 500 mg at intervals of not less than two days. The maximum dose is 3.0 g per day. Examples of b.i.d. or t.i.d. dosage convenience provided by ALDOMET 500 mg within the usual daily dosage range of 500 mg to 2.0 g:

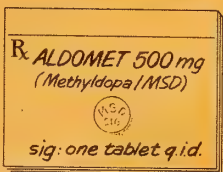
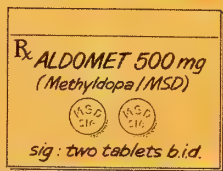
1.0-g
daily
dose =



1.5-g
daily
dose =



2.0-g
daily
dose =

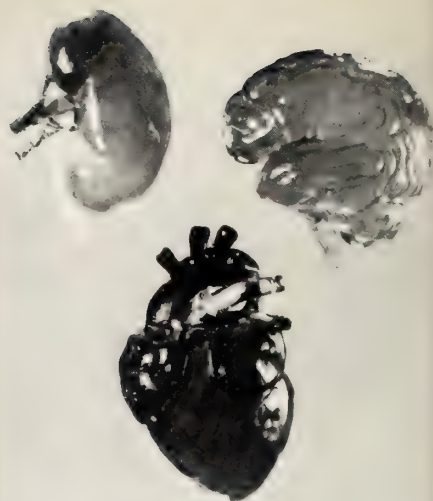


NOTE: Tablets shown are not actual size.

in hypertension

ALDOMET[®] (METHYLDOPA|MSD)

usually lowers blood pressure effectively



Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or

cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reaction or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movement occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patient on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness; symptoms of cerebrovascular insufficiency: paresthesias, parkinsonism, Bell's palsy, involuntary choreoathetotic movements; psychic disturbances: including nightmares and reversible mild psychosis or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatulence, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, skin rash.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensive other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Sympathy in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000. Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MS representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck Co., Inc., West Point, Pa. 19486

MSD MERCK SHARP & DOHME

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Guest Editorial

**Business Recovery
Is In Sight**

THE economy is approaching the trough of its long downturn which, in fact, has been two recessions back-to-back. The first, which ran from December 1973 through August 1974, was brought on by shortages of basic industrial commodities, energy and food. The second, which started in the fall of 1974, was precipitated by a classic business cycle slump in demand.

Some recent favorable developments suggesting that the recession will "bottom out" and that recovery will occur later this year are:

- Passage of the \$23 billion Tax Reduction Act of 1975 involving a close to \$50 billion (annual-rate) boost in after-tax income in the current quarter.
- Lower interest rates.
- More funds available for lending.
- A pronounced rise—at long last—in the money supply.
- Revival of the stock market (with its positive effect on consumer psychology).
- Continued easing in the burden of consumer debt, especially installment debt.
- Continued reduction of top-heavy inventories.
- Continued deceleration in the pace of inflation.

Though recovery is expected in the second half, it will not be robust or broadly based at first, but will gain momentum early next year.

Unemployment should peak this summer and decline gradually thereafter, though it will lag behind the recovery pace and remain undesirably high in 1976.

The big question marks in the outlook are Congressional spending plans and Federal Reserve monetary policy.—**Carl H. Madden, chief economist, Chamber of Commerce of the U.S.**

ruling on a suit filed by Hoffmann-LaRoche, Inc., permanently enjoined the FDA from allowing drugs to be marketed without an approved new drug application. The FDA has allowed makers of generic forms of drugs, after the patent period has expired, to market their own formulations without filing a new drug application. Judge Green stated that the FDA was acting contrary to clear statutory directives and its own regulations and rejected the argument that it lacked the administrative resources to comply with premarket approval provisions.

Editorial Notes . . .

Bioequivalence and bioavailability, after being proven to be of the utmost importance for many drugs, are now the subject of FDA equivocation. The Pharmaceutical Manufacturers Association wants the FDA to insist on bioequivalence as a requirement for all drugs subject to new drug preclearance; and also to impose the burden of establishing bioequivalence on subsequent manufacturers who have not conducted clinical trials or in vivo tests. In vitro tests may be approved by FDA—the PMA thinks that in vitro tests should not be used to compare two different products unless a correlation can be made with in vivo data.

Eight and one-half years of a double-blind study on 248 persons in Bedford, England, has shown some advantage to the use of tolbutamide in diabetics and no evidence against it. There was no evidence of long-term cardiovascular toxicity. The UGDP study done in the U.S. several years ago, on a poorly constructed clinical investigation plan, showed the opposite and has been the subject of intense controversy ever since. No American has published results from a properly conducted clinical study. Everyone has attempted to interpret and re-interpret the original UGDP flop. The British report may introduce some reliable clinical data to help resolve a question whose solution is long overdue. ◀

Recently, Judge June L. Green,

MAYAN ADVENTURE

Is El Salvador and Guatemala. Sun, Fun and No Regimentation. Mayan Pyramids. Pacific Beaches. Golf and Tennis. Tropical Forests and Smoking Volcanoes. Fresh Lobster. Spanish Churches. Silver Jewelry and Hand-Loomed Material. People as refreshing and delightful as small children.



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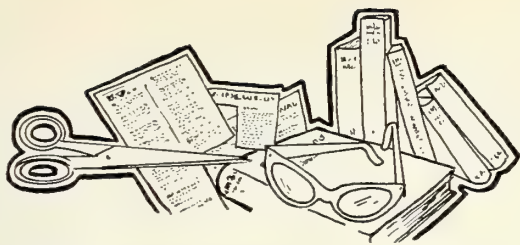
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BOOK REVIEWS

REVIEW OF PHYSIOLOGICAL CHEMISTRY, 15TH EDITION

Harold A. Harper, Ph.D., Lange Medical Publications, Los Altos, Calif., 1975.

This book is represented as focusing primarily on physiological chemistry and designed for individuals desiring to become familiar with the subject or who are preparing for state or Medical Specialty Board examinations. It would seem more appropriate for the latter than for the former.

The book impresses this reviewer as considerably more complex than would be required by—or even useful to—the average practicing physician, except as a reference text. The flexible binding is sturdy, the black-and-white illustrations illustrative and clear. The index is quite adequate, and useful references are appended to each chapter. The book can certainly be recommended wholeheartedly to the target audience.

W. D. SNIVELY, JR., M.D.
Evansville

THE SPEED CULTURE: AMPHETAMINE USE AND ABUSE IN AMERICA

Lester Grinspoon, M.D., Peter Hedblom, Harvard University Press, Cambridge, Mass., 1975; 340 pages, \$15.00.

Amphetamine drugs were first synthesized in the late nineteenth century; however, medical uses for them were not observed until 1927. The drug was first marketed in the United States in 1937, under the trade name Benzedrine. *The Speed Culture* is an analysis of the therapeutic and non-therapeutic uses to which the drug has been put and of the role that "speed" has played in the "deviant" subculture. It seeks to explain the popularity of amphetamine drugs by examining American social and cultural traditions.

Lester Grinspoon, M.D., the author of *Marihuana Reconsidered*, is associate professor of psychiatry at the Harvard University Medical School and director of psychiatric research at the Massachusetts Mental Health Center. Peter Hedblom is the author of several articles on amphetamines and drug abuse.

In their book Grinspoon and Hedblom conclude that amphetamines can improve human performance, principally on simple tasks, by masking fatigue and increasing self-confidence. However, they also conclude that amphetamines do not help with complicated intellectual work and may even make it more difficult by inducing anxiety, restlessness, or overestimation of one's capacities. They indicate that it has not yet been conclusively established whether an athlete's physical endurance and capacity are favorably affected by use of these drugs.

The authors are convinced that substantial clinical evidence exists to support the proposition that psychological and physiological damage can be caused by use of amphetamines. For example, they cite numerous studies which suggest that an amphetamine psychosis can result from chronic amphetamine abuse. They further observe that studies with humans implicate amphetamines in cases of blood dyscrasia, movement disorder and hyperpyrexia.

With respect to the use of amphetamines to treat what is known as hyperkinesis, Grinspoon and Hedblom note that much of the confusion which exists in this area is related to the fact that medical experts have not reached agreement about the nature of the hyperkinetic syndrome.

The Speed Culture merits praise because of its comprehensiveness and attention to detail in presenting the problems that have attended the use of amphetamine drugs in the United States. It also merits praise because of its warning that the more successful the enforcement of a drug prohibition, the more crime will be associated with a dependency-producing drug, even when the capacity to induce antisocial behavior is not one of the inherent properties of that drug. Specifically, the book wisely notes that a total prohibition on the use and manufacture of amphetamines in this country could conceivably aggravate the crime problem. In fact, given the capacity of high doses of amphetamine to produce violent assaultiveness and paranoia, there might be more to fear from a prohibition of amphetamines than there is with heroin.

The only criticism that can be made of the book concerns the difficulty in reading and understanding it that will likely be encountered by a person who is not familiar with medical terminology.

This book should be of interest to physicians, sociologists, drug abuse counselors and students of the American drug scene.

JOSEPH L. ZENTNER
University of California, Berkeley

HOW TO BEAT FATIGUE

Linda Pembrook, Doubleday & Company, New York, 1975.

Linda Pembrook has done a thorough job of research prior to writing *How to Beat Fatigue*. She richly deserves the comment of Donald T. Fredrickson, M.D., in the introduction: "... she presents an authoritative up-to-date review of what we know about the causes and cures of fatigue." Far from being sensational and bristling with the slick tricks that so often characterize medical books for the laity, this little volume contains a wealth of solid, sound information that gets into such topics as controlling time, how much sleep is enough, the hazards of drugs and alcohol, the tired housewife, and the relationship between fatigue and depression. The book is enthusiastically recommended for anyone who wants to beat fatigue. And who doesn't?

W. D. SNIVELY, JR., M.D.
Evansville

REVIEW OF MEDICAL PHYSIOLOGY, SEVENTH EDITION

W. F. Ganong, M.D., Lange Medical Publications, Los Altos, Calif., 1975.

The 7th edition of *Review of Medical Physiology* exemplifies the splendid practice of Lange Medical Publications of frequent revisions. This text, an updating of the 6th edition, does an excellent job of presenting the essentials of human physiology in a well illustrated, clearly written volume. The text is recommended for medical students and nursing students, as well as for practicing physicians who wish to update their knowledge on this most fundamental of all medical disciplines.

W. D. SNIVELY, JR., M.D.
Evansville

HEAD NURSE

Barbara Villet, Doubleday & Company, New York, 1975.

Head Nurse is represented as an in-depth profile of a hospital world. The author is Barbara Villet, whose qualifications include reporting and writing for Life Magazine for some 16

Continued

years—no mean credentials. While the book is presented as nonfiction, narrating events that happened, the central character—as well as the staff and patients depicted in the book—represent a composite drawn from the author's experience. Ms. Villet spent considerable time researching the subject of the book in New York City hospitals, such as Columbia-Presbyterian, Metropolitan, Mount Sinai, and St. Vincent's. The book is highly dramatic, which is not to say that it does not accurately reflect hospital life in the institutions named. For the individual who wants to receive an objective viewpoint of what goes on in a metropolitan hospital, this book is highly recommended. Reading it may be to some extent a disillusioning experience, especially for the non-health professional.

W. D. SNIVELY, JR., M.D.
Evansville

POEMS ON LOVING, LIVING, AND BELIEVING

J. C. Bacala, M.D., Vantage Press, New York, 1975; 104 pages.

Dr. Bacala has a long history of intellectual endeavor dating back to the 1940s in his native Philippines, where he was a professor of nursing and ethics. He now resides and practices in Scottsburg, Indiana, and is a poet. The present volume was privately financed by the author through a prominent subsidized publishing house and is a fine little production.

The author is steeped in Thomistic philosophy and has his special humanitarianism, both of which are prominent components of his poetry. Most of it is free verse and comprises selections from the author's literary production from his marriage in 1949 until today. He constantly reiterates, re-

phrases and repeats his respect for the Christian virtues and his own love of God. I read a few selections to my wife and she said: "I like him—he has something to say."

I won't quote from the volume here because each poem is part of the woof and warp of his entire intellectual and spiritual life. The volume probably should be read in its entirety.

The ideas here are elevating and I feel that I am a better person for having read it. What of criticism? Briefly, Dr. Bacala's long suit is idea and faith while his imagery seems to be thin. The book is roughly chronological and I believe his use of metaphor and figurative phrasing improves as the author ages.

Highly recommended for any of us troubled by the crisis of decreased faith in the eternal verities. We could all benefit by an occasional reflection on the life view of Dr. Bacala. This is a good bedside book.

RODNEY A. MANNION, M.D.
LaPorte

USES OF WINE IN MEDICAL PRACTICE— A SUMMARY

Wine Advisory Board, San Francisco, Ninth Edition—revised June 1975.

The ancient proverb has it: "In vino veritas," that is, in wine is truth. The Wine Advisory Board believes this to the fullest measure and publishes this booklet to prove it to the medical profession and others. There are 12 chapters and the topic is covered exhaustively. They include the chemistry and physiology of wine and various clinical usages. Incidentally, wine has numerous components, including esters (which contribute

When **impotence** due to
androgenic deficiency

is driving them apart



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Android® - 25 ORAL Tabs

Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandro-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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flavor), carbohydrates, pigments and tannens, vitamins (especially B) and trace elements.

There is a body of "wine literature" and each chapter is followed by a bibliography. Whether wine is good (as the writers of this booklet contend) or bad (as prohibitionists contend), it certainly has excited a large interest in mankind. No mention is made of "empty calories," in fact, wine is touted (here) to be an excellent *source* of calories for diabetics and people on a low sugar diet. Some of these contentions seem to be at least slightly controversial but there is no argument when they advise wine and alcohol in general as a tranquilizer. It is that! There is no argument, either, with the carminative effect. It is only that there is very little truly scientific rationale to wine usage and the major indications for wine remain mostly folklore, in my opinion.

Incidentally, this book states that alcohol users are at risk for cirrhosis when more than 80 gms of pure alcohol are consumed daily. That is, about 200 cc of 100 proof whiskey—and that is only 6 or 7 oz.! Thus the use of wine may be a healthy habit but every night shouldn't be Saturday night and, as with most of life's good things, moderation is the key to success.

RODNEY A. MANNION, M.D.
LaPorte

FUNCTIONS OF THE STOMACH AND INTESTINE

M. H. F. Friedman, Ph.D., editor, University Park Press, Baltimore; symposium held in November 1973 as a memorial to J. Earl Thomas, late professor of physiology at Jefferson Medical College, Philadelphia; some 26 papers in three sections; 470 pages with numerous tables and illustrations; \$19.50.

A couple of years ago, I chanced to discuss "Advances in Biophysics," M. Kotani, editor. *JISMA*, July 1973, page 664. I would recommend a quick scanning of that classic before delving into the volume now being reviewed. In Session I, the gastrointestinal motor activities are analyzed with great clarity and insight using a minimum of words: very good, indeed. My Ph.D. thesis (some four decades ago) dealt (rather diffidently) with the Ca^{++} metabolism now being clarified.

Session II deals with the GI secretory activities: both the histamine receptors (they stimulate gastric secretion), the H_1 receptors that can be blocked by conventional drugs such as mepyramine, and the H_2 that go on acting regardless. An excellent updating on an expanding topic.

Session III dealt with the secretory and absorptive activities of the intestine and biliary tract: very clear, concise and informative. The final Session (IV) dealt with the pathological physiology of the GI tract.

All in all, excellent summation that is not only a MUST for the GI expert but is highly recommended for the M.D., whatever his specialty.

ARNOLD LIEBERMAN, M.D.
New York City

THE CIBA FOUNDATION: AN ANALYTICAL HISTORY 1949-1974

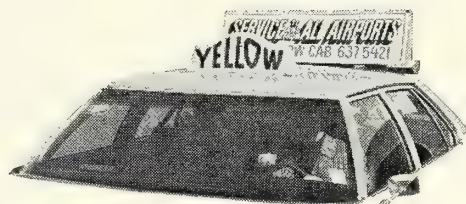
Edited by F. Peter Woodford, Elsevier Publishing Co., New York, 1974; 210 pages.

This volume is exactly what it says: a catalogue of the Ciba Foundation activities since its inception, just what was done where, what went unpublished, etc. The appendices are massive: the names of all contributors, the list of trustees, the plates with armorial bearings, photos of the meeting places, as well as an excellent photo of G. Wolstenholme who has toiled so well—but why go on?

This historical volume belongs in hospital libraries and medical school shelves. As usual, the printing, binding and paper are up to their exacting standards.

ARNOLD LIEBERMAN, M.D.
New York City

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Reports of Officers

Eighth Trustee District



**RICHARD
INGRAM, M.D.**
Trustee

The Eighth District Medical Society met at the Portland Country Club on June 4, with approximately 20 members and their guests on hand for the business meeting.

The District concerned itself with the Health Service Areas, discussion of the new Medical Practice Act and the Medical Liability Bill.

The district adopted a resolution expressing its appreciation to Dr. Richard G. Ingram for the many years of service he has given to the district.

Officers elected were Dr. Jack M. Walker of Muncie as Trustee to succeed Doctor Ingram. Dr. Joseph Gahimer of Anderson was elected president and Dr. James A. Moneyhun of Anderson was elected secretary-treasurer.

The location and date of the 1976 meeting will be given later.

RICHARD G. INGRAM, M.D.
Trustee

Supplemental Report of Executive Committee

Medical Defense Activities

1. Malpractice Cases. A year ago at the time of this report, August 1974, the following six cases were pending before the committee:

Case 313—Suit filed Sept. 5, 1967. Pending. (Expense to date \$600.00)

Case 314—Suit filed approximately July 6, 1970. Pending.

Case 316—Suit filed July 2, 1970. Pending.

Case 318—Date suit was filed unknown. Closed. (Expense \$2,000.00)

Case 320—Suit filed Feb. 4, 1974. Closed. (Expense \$1,389.50)

Case 321—Suit filed May 30, 1974. Pending.

Since Aug. 1, 1974 and to Aug. 1, 1975, three new cases have been filed, one of which has been closed—Case No. 322. (Expense \$2,000.00)

2. Medical Defense Fund Statement from July 1, 1974, to June 30, 1975:

Bank Balance, July 1, 1974 \$24,756.96
Receipts 5,649.48

Total cash and receipts,
June 30, 1975 \$30,406.44
U. S. Treasury Bonds 25,077.67
Payable to General Fund 950.65

Supplemental Report of the Commission on Medical Education and Licensure

The list of approved hospitals and societies was incomplete as published in the September Journal. A complete list follows:

Huntington Hospital, Huntington
St. Mary Mercy Medical Center, Gary
Bloomington Hospital, Bloomington
Lafayette Medical Foundation, Lafayette
Methodist Hospital of Indiana, Indianapolis
Gary Methodist Hospital, Gary
Caylor-Nickel Clinic, Bluffton
St. Catherine Hospital of East Chicago

St. Joseph Memorial Hospital, Kokomo
Ball Memorial Hospital, Muncie
Union Hospital, Terre Haute
Community Hospital, Indianapolis
Indiana Philippine Medical Society
Indiana Society for Internal Medicine
Indiana Psychiatric Society

Treasurer

In previous years we have published an abbreviated report in the September issue and carried the complete audit in the January issue of *The Journal*. The reason for this was that the audit is not made until after the close of our fiscal year (Sept. 30) and is never available in time to submit to the House of Delegates.

As was done last year, I am presenting an unaudited report of the financial condition as of June 30, 1975, and the figures from the Sept. 30, 1974 audit, for comparison. I hope in this way it will give our members a more current review of the financial condition of the State Association.

HUGH K. THATCHER, JR., M.D.
Treasurer

INDIANA STATE MEDICAL ASSOCIATION Statement of Financial Condition

	ASSETS	
	6/30/75	9/30/74
GENERAL FUND:		
Cash on deposit	\$ 54,434	\$ 171,535
Investments—at cost:		
U.S. Treasury Bonds—long term	55,135	55,135
U.S. Treasury Bills—short term	409,471	186,936
Mutual Fund shares	—	32,140
Accounts receivable	14,615	28,449
Prepaid expense	10,848	26,092
Office furniture and equipment—net of accumulated depreciation	18,591	20,340
	<u>563,094</u>	<u>520,627</u>
BUILDING FUND:		
Cash on deposit	1,168	2,014
Cash in savings account	7,626	7,309
U.S. Treasury Bills	231,967	205,271
Prepaid expense	1,481	768
Accounts receivable	328	—
Headquarters property		
Land	69,188	69,188
Office building and improvements—net of accumulated depreciation	236,522	243,435
Rental properties—net of accumulated depreciation	75,486	76,919
	<u>623,766</u>	<u>604,904</u>
STUDENT LOAN FUND:		
Cash in savings account	19,190	19,190
Certificates of deposit	20,810	20,810
	<u>40,000</u>	<u>40,000</u>
MEDICAL DEFENSE FUND:		
Cash on deposit	—	931
Cash in savings account	30,406	26,575
U.S. Treasury Bonds—long term	25,078	25,315
	<u>55,484</u>	<u>52,821</u>
	<u>\$1,282,344</u>	<u>\$1,218,352</u>

LIABILITIES AND FUND BALANCES

GENERAL FUND:

Accounts payable	\$ 24,828	\$ 13,822
Payroll taxes withheld	—	2,110
Accrued taxes	—	615
Dues payable to AMERF	20,563	20,660
Advances from AMA	9,278	9,278
Unearned portion of current year dues	254,546	109,371
Dues restricted to Speaker's Bureau	52,197	41,320
Exhibitors' deposits for annual meeting	400	19,533
Advance from Local Health Survey	—	19,149
Lease contracts payable	1,183	1,427
Fund balance	200,099	283,342
	<hr/> 563,094	<hr/> 520,627

BUILDING FUND:

Accrued taxes on rental properties	1,886	2,259
Damage deposits and accounts payable	1,046	3,128
Loans from members (non-interest bearing)	20,025	20,275
Fund balance	600,809	579,242
	<hr/> 623,766	<hr/> 604,904

STUDENT LOAN FUND:

Fund balance	40,000	40,000
	<hr/> 40,000	<hr/> 40,000

MEDICAL DEFENSE FUND:

Payable to General Fund	951	—
Fund balance	54,533	52,821
	<hr/> 55,484	<hr/> 52,821
	<hr/> \$1,282,344	<hr/> \$1,218,352

Resolutions

Resolution No. 75-29

Introduced by: Section on Ophthalmology and Otolaryngology
Subject: OPPOSITION TO NEW REGULATIONS ON FEES

Referred to:

Whereas, The U. S. Department of Health, Education, and Welfare has issued a ruling respecting Medicare reimbursements for physicians' services, which ruling was published in the Federal Register on June 16, 1975; and

Whereas, Said ruling would limit Medicare reimbursements to the lower of the following: the physician's usual and customary fee during the calendar year 1974; the prevailing fee in the relevant geographical area during the calendar year 1974; or the prevailing fee in the relevant geographical area for the calendar year 1971 with an economic index adjustment of 1.1793; and

Whereas, Said ruling, by gearing Medicare reimbursements in part to the physician's usual and customary fee, discriminates between the Medicare patients of one physician and the Medicare patients of another, in that both have been subject to the same Social Security taxes but are nevertheless receiving disparate benefits; and

Whereas, Said ruling, by gearing Medicare reimbursements in part to the

prevailing fee in the relevant geographical area, discriminates between patients utilizing physicians' services in one area and patients utilizing physicians' services in another area, in that both have been subject to the same Social Security taxes and are nevertheless receiving disparate benefits; and

Whereas, Said ruling, by gearing Medicare reimbursements in part to the fee prevailing in the relevant geographical area during the calendar year 1971, incorporates mandatory price stabilization concepts and policies that have been discredited and that no longer apply to any other sector of the economy; therefore, be it

Resolved, That the Indiana State Medical Association hereby objects to the ruling of the U. S. Department of Health, Education and Welfare respecting Medicare reimbursements for physicians' services published in the Federal Register on June 16, 1975, as being unfair and discriminatory.

Resolution No. 75-30

Introduced by: Fort Wayne-Allen County Medical Society
Subject: CANCER SOCIETY STATEMENTS

Referred to:

Whereas, A recent publication of the American Cancer Society titled "Ameri-

can Cancer Society Policy Statement on the Surgical Treatment of Breast Cancer" was reviewed by the Board of Trustees of the Fort Wayne-Allen County Medical Society, and

Whereas, The contents of said statement intended for distribution to the lay public was more confusing than educational, was quasi-professional in tone, and seemed to cross that tenuous border between concise lay education and medical instruction; now, therefore, be it

Resolved, That the Indiana State Medical Association, through its proper liaison committee, ask the American Cancer Society to cease and desist in such policy statements.

Resolution No. 75-31

Introduced by: Frederic L. Schoen, M.D.
Subject: LEGISLATION DEFINING PHYSICIAN'S ASSISTANT

Referred to:

Whereas, The Indiana University School of Medicine is actively training Physician's Assistants in Indiana; and

Whereas, The Physician's Assistants are being trained as Assistants to the Primary Care Physician; and

Whereas, The twenty-two Physicians' Assistants in Indiana are functioning in needed areas of Indiana with Primary Care Physicians; and

Whereas, There is a need to enact supporting legislation for the utilization of Physician's Assistants in Indiana; and

Whereas, There is a need for strong support for such legislation from the Indiana State Medical Association; therefore, be it

Resolved, That this House of Delegates of the Indiana State Medical Association directs the Board of Trustees to actively indicate its support of the concept of Physician's Assistants by:

1. Working with the Physician's Assistant Program of Indiana University School of Medicine and the Indiana Academy of Physician's Assistants in drafting enabling legislation authorizing the control and utilization of Physician's Assistants in Indiana; and by
2. Working with said program and organization to promote the enactment of such legislation by personal testimony and other measures in the 1976 General Assembly of the state of Indiana.

Additional Scientific Exhibits

ASPIRATION NEEDLE LUNG BIOPSY: A SAFE, PRACTICAL, HIGH-YIELD DIAGNOSTIC PROCEDURE
Exhibitor: Carl H. Linge, M.D.

Welborn Hospital
 Evansville

Co-exhibitor: William E. Adamson, M.D.
 Welborn Hospital

Attendants: Drs. Linge and Adamson
Aspiration needle biopsy of pulmonary lesions is safe, uncomplicated, and highly accurate in obtaining a diagnosis. Close cooperation between radiologist and pathologist is essential. Technical aspects of performing the biopsy are described. Several cases are presented, showing chest radiographs and the diagnostic cytology and histology photomicrographs.

HEARING LOSS

Exhibitor: Claude P. Hobeika, M.D.
Cincinnati, Ohio
Attendants: Claude P. Hobeika, M.D.,
Toni Van Horn, Mell Gross
and Micki Coppel

The purpose of this exhibit is:

1. To show the importance of normal hearing, especially in children, and how it affects their performance in school.
2. How to differentiate between the different types of hearing loss.
3. To present the different treatments now available: medical, surgical, prosthetics.

GINSENG

Exhibitor: W. P. Loh, M.D.
Gary
Co-Exhibitor: C. P. Li, M.D.
Arlington, Va.

Attendants: Drs Loh and Li and others
Ginseng is a well known Oriental herbal medicine. In recent years this medicine has become popular in the United States and various preparations containing this medicine are now available at many drugstores (such as Walgreen). The medical profession and others are entitled to know more about this medicine. This is a timely presentation which will summarize the scientific aspects of this medicine. History, special research and clinical applications are also included in the presentation.

Additional Technical Exhibitors

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T. L. Bishop
M. L. Walsman

COULTER ELECTRONICS, INC.
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Hialeah, Fla.

Robert Canada

GENERAL MEDICAL INDIANA
1850 W. 15th Street

Indianapolis

Jack Watts

MARION LABORATORIES
10236 Bunker Ridge Road
Kansas City, Mo.

Al Cushing
John Yount

CARTER, QUIMBY, SCHEMME & ASSOCIATES, INC.
3901 N. Meridian Street

Indianapolis

Dave Quimby

Resolutions

Resolution No. 75-32

Introduced by: Board of Trustees
Subject: DUES INCREASE
Referred to:

Whereas, Your Board of Trustees, by action of this House is responsible for continuous monitoring of the fiscal condition of this Association; and

Whereas, A deficit was created by

our legislative effort on H.B. 1460; and

Whereas, We can anticipate additional expenditures in the coming legislative session and for any court case testing the constitutionality of the Professional Liability Law as well as further inflation; therefore, be it

Resolved, That effective January 1, 1976, the dues be increased by ten dollars (\$10.00); and be it further

Resolved that the ten dollar increase of 1974 for the Speakers Bureau be retained as well as the ten dollar increase in 1975 for legislative activity; and be it further

Resolved, That these funds be credited to the General Fund, the expenditure to be subject to the Budget Committee and the Board.

Continued on page 914



THE SINGING DOCTORS will entertain at French Lick at the annual dinner of the Board of Trustees on Sunday, Oct. 19. All of Evansville, they are (front row, left to right): Drs. Jerry Becker, Robert Penkava, Emil Weber; second row: Drs. James R. Mathews, Ned P. Rule, Forrest F. Radcliff and Richard H. Russell (deceased); back row: Drs. Jerry Hoover, director; Ed Pfafflin (D.D.S.), William H. Allen, L. Ray Stewart, Charles Hachmeister, Henry Leibundguth, and Robert L. Harris.

FUTURE MEETINGS, SEMINARS, COURSES

Pediatric Allergy Symposium in Israel

The Fourth International Symposium on Pediatric Allergy will be held Nov. 3 to 16 in Israel. Travel arrangements may be made with optional tours. Write Foreign Tours, 1140 Avenue of the Americas, New York City 10036; or El Al Israel Airlines, 850 Third Ave., New York City.

Kidney Foundation and Dialysis and Transplant Forum to Meet in November

The National Kidney Foundation Annual Meeting and Scientific Sessions will be held at the New York Hilton Hotel Nov. 20 to 23. The annual meeting of the Clinical Dialysis and Transplant Forum will be Nov. 22 and 23 in conjunction with the Foundation meeting. For full information write the Foundation at 116 E. 27th St., New York City 10016.

Baylor Announces Course on Depression

Baylor College of Medicine, Texas Medical Center, Houston, will conduct a two-day course on "Phenomenology and Treatment of Depression," Dec. 4 and 5. The subject matter will be presented for the interests of psychiatrists, internists and family practitioners. Write Dr. Fred M. Taylor for details.

Mexico Site of International Symposium

The University of Oklahoma is sponsoring, with the National Academy of Medicine of Mexico, the "Inter-American Symposium on Internal Medicine," to be held in Mexico City, Jan. 12-15, 1976. The theme of the course will be "What's New in Diagnosis and Therapy?" Full details on the course, group air fares, accommodations and post-symposium tours may be obtained by writing James F. Hammarsten, M.D., P.O. Box 26901, Oklahoma City, Okla. 73190.

Conference Scheduled in Virgin Islands

The First Mid-Winter Virgin Islands Clinical Conference will be held in St. Thomas, Jan. 29-31, 1976, by the U.S. Virgin Islands Medical Society in association with The Faculty of the University of Pennsylvania School of Medicine.

This program is acceptable for 14 credit hours in Category 1 for the Physician's Recognition Award of the AMA, and will include lectures and seminars of interest to the physician in General Practice, Internal Medicine, General Surgery and OB-Gyn.

For further information, write AIRMAIL to: Harold A. Hanno, M.D., F.A.C.P., Secretary, U.S. Virgin Islands Medical Society, Box 1442, St. Thomas, Virgin Islands 00801.

Nevada Tumor Registry Announces 1976 Conference on Cancer Control

The Third Spring Conference on Cancer Control sponsored by the Nevada Tumor Registry will be held in Las Vegas on March 11 and 12, 1976. For full details write Irene S. Peacock, 1800 W. Charleston Blvd., Las Vegas, Nevada 89102.

Radiology of Trauma Course in March

A three-day postgraduate course will be held at the Indiana University School of Medicine Mar. 17-19, 1976. This course will review basic concepts of trauma roentgenography. Course objectives are to correlate the technical, clinical and pathological aspects of radiology of trauma. Distinguished guests will join with several members of the Indiana University faculty as speakers. The registration fee will be \$150; for residents, \$75.

For further information, contact: Division of Postgraduate Medical Education, School of Medicine, 1100 West Michigan St., Indianapolis 46202.

Florida Seminar in Emergency Medicine

"Advanced Life Support: The Fourth Annual Postgraduate Seminar in Emergency Medicine" will be held Mar. 19-22, 1976, at the Americana Hotel, Miami Beach. Sponsored by the Florida chapters of the American College of Emergency Physicians and the Emergency Department Nurses Association. For further information write the Registrar, 1976 PGS, 1919 Beachway Road, Suite 5-C, Jacksonville, Fla. 33207, or phone 904-399-0510.

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Urinary Tract Radiology Course Offered

Duke University Medical Center will conduct a tutorial postgraduate course on "Radiology of the Urinary Tract" in Durham, N.C., March 22 to 26, 1976. Enrollment will be limited to 100. Registration fee is \$300. Write to Dr. Robert McClelland, Radiology-Box 3808, Duke University, Durham, N.C. 27710.

Clinical Neuro-Otolaryngology Course

The University of Pittsburgh School of Medicine will conduct the Third Course in Clinical Neuro-otolaryngology at the Eye and Ear Hospital of Pittsburgh on March 25 to 27, 1976. For full particulars write Dr. Sidney N. Busis, at the hospital, zip 15213.

Gynecologic Cancer Management Course Scheduled by I.U. School of Medicine

I. U. School of Medicine will conduct a course on "Current Concepts in Management of Gynecologic Cancer" on May 20 and 21, 1976. Special interest to family practitioners, internists, Ob-Gyn specialists and radiation therapists. Latest detection and treatment methods will be covered. Several nationally known speakers will participate.

"Frontiers of Medicine" Series To Be Held at Billings Hospital

The University of Chicago "Frontiers of Medicine" starts its eleventh series this fall. The second Wednesday of each month, September to June, will be devoted to either afternoon or all-day sessions. The fee for the entire series is \$125. A half-day session is \$20, whole days \$30. Lunches are not included. Physicians are asked to register in advance. For more information write Louis Cohen, M.D., University of Chicago, BH Box 451, 950 E. 59th St., Chicago 60637. All programs are in the Frank Billings Auditorium in Billings Hospital. Meeting days and subjects are as follows:

October 29, 1975—All day program (Location to be announced)

SLEEP DISORDERS

November 12, 1975

FRONTIERS OF EMERGENCY MEDICINE

December 10, 1975

ADVANCES IN THE DIAGNOSIS AND MANAGEMENT OF HYPERTENSION

February 11, 1976

LUNG CANCER

March 10, 1976—All day program

ADVANCES IN PERINATOLOGY

April 14, 1976—All day program

GASTROESOPHAGEAL REFLUX

May 12, 1976

COMMUNITY PROGRAMS IN CLINICAL GENETICS

June 9, 1976—All day program

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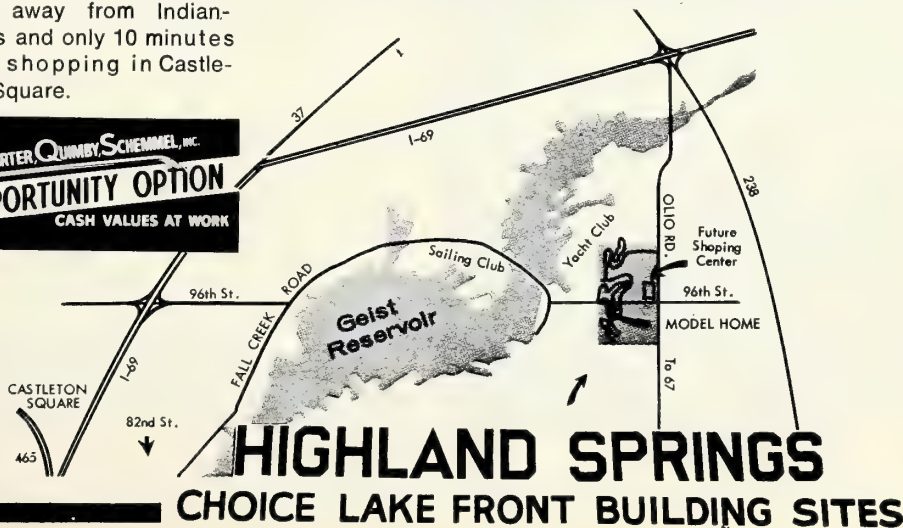
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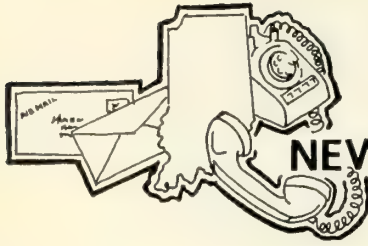
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NEWS NOTES

Continuing Medical Education

The following Indiana physicians have received the AMA Physician's Recognition Award within the past few months:

Drs. Dolores G. Adeva, Westville; **Thomas J. Allen**, Carmel; **Norman E. Beaver**, Berne; **Michael D. Bishop**, Bloomington; **Pilar R. N. Brandewie**, Westville; **Clarence M. Cobb**, Indianapolis; **Richard D. Connelly**, Fort Wayne; **Felicesimo D. Dayar**, Indianapolis; **Joshua L. Edwards**, Indianapolis; **Daniel Richard Evans**, Valparaiso, and **Paul V. Evans**, Indianapolis.

Also, **Drs. James F. Ferguson**, Bloomington; **Morris S. Friedman**, South Bend; **Noli C. Guinigundo**, Brookville; **David K. Johnloz**, Bloomington; **Robert F. Kimbrough**, Fort Wayne; **David H. Kingsbury**, Indianapolis; **Kenneth W. Koss**, Muncie; **Richard G. Luzietti**, Bluffton; **Richard F. Lyster**, Fort Wayne, and **Dean D. Maglinte**, Indianapolis.

Also, **Carl D. Martz**, Indianapolis; **Glenn B. Mather**, Bloomington; **Abouzarjomebr Mazdai**, Connersville; **James P. Mitchell**, Bloomington; **Anastacio C. Ng**, Indianapolis; **William A. Nice**, Bloomington, and **Surjit S. Patheja**, Valparaiso.

Others earning the award in July were: **Drs. Harold G. Petitjean**, Haubstadt; **Larry D. Ratts**, Bloomington; **Manuel Z. Rosario**, Gary; **Iver F. Small**, Indianapolis; **Carl B. Sputh**, Indianapolis; **Douglas A. Triplett**, Muncie; **Leonorio B. Tuason**, Martinsville; **William M. Wable**, Indianapolis; **Robert M. Walker**, Ellettsville, and **Joe Irvin Willman**, Gaston.

Medical Malpractice Self-Insurance Information Sought by Dr. L. Lenyo

All Indiana physicians interested in forming a medical liability self-insurance program are asked to contact **Dr. L. Lenyo**, president, Vigo County Medical Society, 2100 Center, Terre Haute 47804, prior to the ISMA annual meeting.

Independent Living for Handicapped

The latest Public Affairs Pamphlet is entitled "Independent Living: New Goal for Disabled Persons." The author looks at the problems handicapped people face, the feasibility of living alone, and the choices open to those disabled persons who want to try an alternative lifestyle. The Pamphlet is #522. Price is 35 cents. Address is 381 Park Avenue South, New York City 10016.

Welborn Hospital Medical Staff Elects

Dr. John F. Lawler recently became president of the Welborn Hospital medical staff. **Dr. Jack O. Williams** was chosen president-elect and **Dr. Alfred Lessure**, secretary-treasurer. Serving as members of the Executive Committee-at-large are **Drs. Marshall S. Miller**, **Raymond L. Brown** and **Fawzy Salama**. Also on the Executive Committee are **Dr. John B. Kelly**, immediate past president; **Dr. William A. Vincent**, internal medicine chief; **Dr. Leon Stoller**, chief of obstetrics and gynecology; **Dr. Larry Beisel**, chief of pediatrics, and **Dr. Ben K. Harned, Jr.**, chief of surgery.

Malpractice Task Force Appointed

Members of the Medical Malpractice Study Commission provided for by H.B. 1460 have been named. They are: **Drs. Gilbert Wilhelmus** and **William R. Cast**, representing the medical profession, **Don Hamachek**, representative of the Indiana Hospital Association, **John Carr Jr.** and **Charles W. Hoodenpyl**, representing the Indiana bar; **H. P. Hudson**, Indiana Insurance Commissioner; State Representatives **Philip T. Warner** and **Joe Harris**; State Senators **Adam Benjamin** and **Leslie Duvall**, and **Betty Mumaw** and **Willis Zagrovich**, individuals not associated with the hospital or insurance industries, medicine or the practice of law.

The Commission is mandated to perform its task and must report its findings to the Governor on or before Dec. 1, and again Sept. 1, 1976, with a final report by Dec. 31, 1976.

Hoosiers Give Medical Assistance In Africa and Dominican Republic

Among Hoosier physicians who have participated in medical mission programs within the past year have been **Drs. Hunter A. Soper**, Indianapolis, and **Dr. Neil Irick**, Markle. Dr. Soper supervised the work of three senior medical students at the Piper Memorial Hospital in Zapanga, Zaire (formerly Congo) from January through March. Dr. Irick spent six months assisting at a new mission hospital in Mutumbura, Rhodesia, and is presently at the Piper Memorial Hospital on another six-month commitment. These are mission hospitals supported by the United Methodist Church.

Dr. Jack Kelley, Lafayette, along with his wife and two daughters, participated in a brief missionary journey to the Dominican Republic in July sponsored by the Medical Group Mission Programs of the Christian Medical Society.

Other Lafayette physicians who have participated in similar outreach programs and **Dr. Jacob Scheeres**, **Dr. Charles Rutherford** and **Dr. Charles Patton**.

Unusual Hobbies Highlighted

The unusual hobbies of two Indiana physicians have been featured in Hoosier newspapers recently.

For the past seven summers **Dr. Lloyd Hill**, Peru, has participated in a three-ring amateur circus presented by residents of the "Circus Capital of the World," performing as a clown complete with greasepaint, baggy pants and floppy shoes. According to the Associated Press feature, "the Peru circus is the largest amateur production in the U.S., boasting of acts performed only by the top pro shows."

Dr. Don A. Sears, Odon, flies a kite—in fact, he flies with the kite, over water. He is pulled along on water skis by a power boat until sufficient speed is attained and he can become air-borne by maneuvering his kite. Things like cross winds and down drafts pose hazards that led to a crash and some broken ribs last year but have not diminished his zeal for the sport.

Named Kosciusko County Health Officer

Dr. Michael Dacquist, Warsaw, has been appointed Kosciusko County Health Officer to fill the vacancy created by the resignation of **Dr. George Ros**.

Honored at Retirement Party

Honored recently at a retirement party given by the anesthesiologists, surgeons, operating room staff and recovery room staff at Ball Memorial Hospital was **Dr. William B. Adams**, Muncie anesthesiologist who has been at Ball Hospital for the past 34 years.

Honored for 25 Years of Service

Three physicians were recognized for 25 years of service on the medical staff of Elkhart General Hospital at the hospital's annual recognition dinner recently. They are: **Drs. Elmer R. Billings, Lloyd O. Rupe and C. Richard Yoder, all of Elkhart.**

Appointed Allen County Coroner

Dr. Roland C. Ahlbrand, Fort Wayne, was sworn in as Allen County coroner last month following the resignation of Dr. Gordon Franke.

Speaks to Diabetic Group

Dr. George Waters, Indianapolis, spoke on diabetes and the eyes to a recent meeting of the Diabetic Interest Group in the Hendricks County Hospital Education Area.

Named to NAACP Chairmanship

Dr. Benjamin F. Grant, Gary, was recently appointed national chairman of the Life Membership Committee of the National Association for the Advancement of Colored People. He succeeds entertainer Sammy Davis Jr. in the post.

Dr. Kindell's Anniversary Featured

Dr. Hurschell D. Kindell, New Richmond, was the subject of a feature article in the *Crawfordsville Journal and Review* recently. The occasion was the 50th anniversary of his graduation from the Indiana University School of Medicine and his becoming licensed to practice medicine in Indiana. He practiced at Newtown for a year after completing an internship with the United States Navy, moving to New Richmond in 1929.

Police Lodge Honors Dr. Thomas

Dr. Daniel D. Thomas, Gary, recently received the Friendship Award of the State Lodge of Indiana, Fraternal Order of Police, in appreciation of his contributions to the law enforcement profession. Dr. Thomas is a former Gary Police Commissioner.

Dr. Mathewson Retires

Dr. Russell Mathewson, Muncie, retired from his psychiatric practice last month. He will continue his work with the Family Counseling Service of the United Way.

Medical History told by Dr. Mather

Dr. Glenn B. Mather, Bloomington, spoke on Indiana medical history at a recent meeting of the Bloomington Hospital Advisory Council and Board of Directors.

Board Certifies Dr. Vakkur

Dr. George J. Vakkur, South Bend, has been notified of his certification by the American Board of Psychiatry and Neurology.

Receives Unusual Tribute

Dr. Warren V. Morris, Monticello, received an unusual tribute from the people of Monticello recently when they ran a half page advertisement in the Monticello Daily Herald-Tribune congratulating him on the 40th anniversary of his graduation from the Indiana University School of Medicine. Dr. Morris began his practice in Monticello in July 1936, following an internship at Deaconess Hospital, Cincinnati.

Dr. Glover Named Medical Director Of Marion County General Hospital

I. U. School of Medicine, which has utilized the clinical facilities of Marion County General Hospital for many years in varying degrees, and since 1969 through a loose administrative arrangement, has agreed for a two-year-trial of complete medical management. **Dr. John L. Glover**, chairman of surgery at General since 1971 and professor of surgery at I.U. has been chosen as acting medical director of General.

E. Mead Johnson Award Winners Named

The American Academy of Pediatrics announces that John Robbins, M.D., of the FDA, and David Smith, M.D., associate professor of pediatrics at Harvard Medical School, will share one of the two E. Mead Johnson Awards for their work toward development of an immunizing agent against *Hemophilus influenzae*. Rawie McIntosh, M.D., associate professor of pediatrics at the University of Colorado Medical Center, will receive the other E. Mead Johnson Award for his work in the field of immunologic mechanisms in renal disease.

New Medical Building Near Hospital

Ceremonies recently marked the beginning of construction of a building, to be called 1633 Medical Tower, across Capitol Avenue from the Methodist Hospital in Indianapolis. The 12-story building with an attached four-story garage will cost about \$10 million and will include seven floors of medical office condominiums, four floors devoted to 110 hotel rooms, and a ground floor of restaurants and shops. It will connect with the hospital by a fourth floor bridge-like enclosed walkway especially designed to accommodate wheel chairs. It will be the largest precast concrete building in Indiana.



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Pediatrics Academy Elects

Dr. Robert Hanneman, Lafayette, has been elected chairman of the Indiana Chapter of the American Academy of Pediatrics.

Others elected include **Dr. Robert Sweeney, South Bend**, vice-chairman; **Dr. William Ashman, Fort Wayne**, secretary, and **Dr. Michael Hogan, Indianapolis**, treasurer. They are scheduled to take office Nov. 1.

Offers Film on Poison Prevention

Parke-Davis has a new, full color, 14½-minute motion picture to teach young children how to avoid being accidentally poisoned. The film is titled "Teaching Children Poison Prevention" and is available on a free-loan basis from Modern Talking Pictures. Write Parke, Davis & Company, Box 118, General Post Office, Detroit 48232.

Purdue Receives \$25,000 from Elks

Indiana Elks have granted Purdue University \$25,000 in support of cancer research. The funds will be used in part to establish a laboratory for the cultivation of experimental tumor cells.

Fire Protection Library Offered

The National Fire Protection Association advertises for sale their "Health Care Safety: Fire Protection Systems Library" at \$29. It is designed to help administrators to become familiar with pertinent fire protection and fire prevention provisions in hospitals and nursing homes. Write the Association at 470 Atlantic Ave., Boston 02210.

Achieve Diplomate Status in Pathology

The American Board of Pathology announces that the following Indiana physicians are now diplomates, having successfully completed the examinations of May 23 to 26: **William H. Card, Indianapolis**; **Cirilo Farinas, Munster**; **Stephen Hathaway, South Bend**; **Saing Hee Lee, Indianapolis**; **William E. McNally, Anderson**; **Carleton D. Nordschow, Indianapolis**, and **Philip A. Szanto, Munster**.

New Lab Director at Deaconess

Dr. Jerry Rothenberg is joining the Deaconess Hospital at Evansville as director of Laboratories. He comes to Evansville from the Alliance, Ohio, City Hospital.

Dr. W. P. Loh Returns from China

Dr. Wei-Ping Loh, Gary, returned recently from a 22-day visit to China during which he visited the major medical and research institutions in Peking and Shanghai. He reports that he was well received by the Chinese Medical Association, the China Travel Agency and others, adding that he was "deeply impressed by their achievements of self reliance, mass action and absence of crime."

Booklet on Child Motivation Published

Public Affairs Pamphlet #523, "Motivation and Your Child," is devoted to helping children to develop positive motivation at an early age. Alicerose Barman discusses the foundations of motivation, how to encourage healthy motivation and the role of useful aggression. The price is 35 cents. Address is 381 Park Avenue South, New York City 10016.

"New Pulse of Life" Film Available

"New Pulse of Life," a 29-minute color film on cardiopulmonary resuscitation by Pyramid Films is now available for sale at \$300 or for rent at \$25, with 10% discount to American Heart Association and American Red Cross chapters. The film is not intended to replace drill and practice as training methods but to motivate the viewer to take time to learn and practice.

Dr. Siebenmorgen Appointed to Board

Dr. Paul Siebenmorgen, Terre Haute, has been appointed to a four-year term on the Indiana State University Board of Trustees by Governor Otis R. Bowen. The term runs until July 1, 1979.

Addresses Baltimore Symposium

Dr. Robert E. Snodgrass, Indianapolis, spoke on "Psychiatric Emergencies" at the semi-annual postgraduate symposium held recently at Taylor Manor Hospital, Baltimore.

Retirement Announced by Dr. Eisaman

Dr. Jack L. Eisaman, Bluffton, has retired from the practice of medicine. He had been associated with the Caylor-Nickel Clinic and Hospital for nearly 30 years. A past president and secretary-treasurer of the Wells County and the 12th District medical societies, Dr. Eisaman has also been active with the Northeast Indiana Heart Foundation and the Wells County Society for the Crippled.

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Drs. Hill, Kenyon Serve as Marshals

Drs. Hill and Paul Hill, Cambridge City, served as parade marshals for the annual "Canal Days" festival sponsored last month by the Cambridge City Chamber of Commerce. Both are Senior Members of the ISMA.

Film Demonstrates "Heimlich Maneuver"

Teaching film available: "How to Save a Choking Victim: The Heimlich Maneuver." Dr. Heimlich, Cincinnati, demonstrates and explains his maneuver of directing the diaphragm upward to create lung pressure sufficient to dislodge impactions in the larynx. The technic can be performed by any layman. Everyone should be knowledgeable. Choking is the sixth largest cause of accidental death. Write Oxford Films, Los Angeles, California 90038.

Tells of Coroner's Responsibilities

Dr. John Pless, Bedford, Lawrence County coroner and president of the Indiana Coroner's Association, explained the duties of his office at a recent meeting of District 13A, Indiana Volunteer Firemen's Association. Dr. Pless is the only forensic pathologist coroner in Indiana.

Dalkon Shield® Not to Be Re-marketed

A. H. Robins Company has decided to abandon its plans to re-market the Dalkon Shield® intrauterine contraceptive device. Despite their opinion that the Shield, when properly used, is a safe and effective IUD, the long delay imposed by the FDA's failure to develop a patient registry system for its further clinical trial has convinced the company that further expenditure of funds and time is not warranted.

Dr. Russell Gilmore Serves 55 Years

Dr. Russell A. Gilmore, Michigan City, was honored at a recent meeting of the St. Anthony Hospital medical staff for his 55 years of service. A graduate of the University of Illinois Medical School in 1916, Dr. Gilmore served with the Army Medical Corps and then began his practice in Indiana in 1920.

Market Commentary

Backing and filling continues in the marketplace and signs are developing that a bottom area is close; use any further sell-offs to add to portfolios for the remainder of the summer and fall.

CURRENT TREND ANALYSIS

Bottom Area Here or Near

It is practically impossible to pick the exact bottom of a reaction, but with the market having retreated to our expected 750-800 area, we believe we are at or very near to the bottom of the reaction.

The technical action of the market this past week was excellent.

New lows in both averages will suggest further decline, of course, but with the market having reached the projected decline area of 750-800, the risks have been materially reduced from several weeks ago, in our opinion.

At that time, the Dow was hovering around 880 and many were expecting still higher prices. But the Dow Theory was saying otherwise and actually predicted by its divergent action the reaction that soon developed.

Now that the reaction has traced a normal pattern (a decline, a rally and then another decline), we believe clients can again begin to buy stocks more freely.

CURRENT STOCK SELECTIONS

Stocks To Buy

A number of our favorites like RCA, Taft Broadcasting, McGraw-Hill and IBM have backed off nicely and offer excellent buying opportunities, in our opinion. Bell & Howell is down nearly 20% from its recent high and should also prove an excellent buy, as should banks like Continental Illinois, Morgan and Union Bancorp.

A new addition—Disney—is off nearly 30% from its recent high and could prove an excellent long term holding, as could Dome Mines, Dow Jones & Co., Armstrong Cork, Holiday Inns, Howard Johnson, Hyatt and selected brokerage issues.

McGraw-Edison is also down some 20% and should be an excellent buy, as should Public Service of Indiana, Standard Oil of Indiana, Texaco and the very speculative United Nuclear and Tiger International.

If the reaction is bottoming out, all stocks will rally the rest of the summer and this fall, but these particular issues may do better than most.

Conclusions

Indications are beginning to appear that the reaction is in its closing stages. At least the risk of buying is now a great deal less than it was several months ago. Use any further decline to add stocks to your portfolio.—**Dow Theory Forecasts, Sept. 1, 1975. Reprinted with permission.**

NEW PROSTHETIC METHODS OPEN NEW DOORS

New doors have been opened to amputees — thanks to new prosthetic techniques. During the past few years many recent prosthetic developments now offer improved function for the amputee, as well as better appearance and increased comfort.

SILASTIC SILICONE MATERIAL - Silastic is useful in forming distal-bearing or total-contact pads that apply form-fitted pressure on the distal end of stumps. The density of this material may be varied to suit the individual requirements of each amputee.

TOTAL CONTACT SOCKET - Developed by research, this new socket distributes weight bearing over the entire stump. It is particularly helpful in problem cases of poor circulation.

MOLDED SACH FOOT - This Solid-Ankle, Cushion-Heel foot is more durable and its one-piece construction is more pleasing in appearance.

BAN-LON STOCKINETTE - This finer type stockinette when impregnated with plastic provides a more natural finish.

MUENSTER FITTING - Better control with less harness is achieved in this new method of fitting very short—below elbow stumps. The unusual socket shape utilized provides a more intimate fit assuring a more functional prosthesis.

For information on these developments, please write to:

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416 N. Main Street, Evansville, Indiana 47711
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Resolutions

Continued

Resolution No. 75-33

Introduced by: St. Joseph County Medical Society

Subject: HONORARY MEMBERSHIP — MR. HARRY C. DAVIS

Referred to:

Whereas, Harry C. Davis has served with distinction and dedication as the executive secretary for the St. Joseph County Medical Society for over 34 years; and

Whereas, He has earned the respect and admiration of the members of the St. Joseph County Medical Society, other physicians and other medical directors and/or executive secretaries of other medical societies, not only in the state of Indiana but throughout the country; and

Whereas, In addition to his service as executive secretary, he organized and maintained many business services to the community and to the individual area physicians such as Professional Management Service, Doctors Business Bureau, Telephone Answering Service, Radio Page of Michiana, Medical Assistants Association and teaching programs for the Medical Assistants Association; and

Whereas, His service and devotion as executive secretary have been instrumental in the development of better community health care, and because of his outstanding meritorious service to the profession of medicine in St. Joseph County and the state of Indiana and to his colleagues throughout the country; now, therefore, be it

Resolved, In recognition of his long, devoted and faithful service to the medical profession, this House of Delegates,

in accordance with Article IV, Section 7, of the Constitution of the Indiana State Medical Association, unanimously elects Harry C. Davis as Honorary Member of the Indiana State Medical Association.

Resolution No. 75-34

Introduced by: St. Joseph County Medical Society

Subject: ANNUAL ASSESSMENT FOR PROFESSIONAL LIABILITY

Referred to:

Whereas, H.B. 1460 has provided some respite but has not solved Indiana's malpractice situation; and

Whereas, The Ford administration has taken the position that the solution should come from the states and would not be forthcoming from Washington; and

Whereas, There is no real incentive for lawyers or insurance agents to propose corrective actions, which actions, in fact, may be detrimental financially to them; and

Whereas, Physicians must expect to be the main source of any legislation to effect a permanent and equitable solution to the medical liability problem; and, indeed, must accept the responsibility for proposing such legislation; and

Whereas, Proposed legislation involves substantial lobbying and legal expenses; now, therefore, be it

Resolved, That ISMA House of Delegates directs the ISMA Board of Trustees to assess its members thirty dollars (\$30) *this year* and annually for the purpose of improving the medical liability picture in the state until the House of Delegates indicates by further resolution that it recognizes enough improvement to forego this assessment; and be it further

Resolved, That, included in this effort

will be a pooled information system to be developed at ISMA headquarters which will accumulate cost and efficiency information on malpractice in the state of Indiana; and be it further

Resolved, That such funds so collected be kept in a special account and designated for the above purposes.

Resolution No. 75-35

Introduced by: St. Joseph Medical Society

Subject: VALID PATIENT-PLAINTIFF CLAIMS UNDER H.B. 1460

Referred to:

Whereas, The patient-plaintiff who has an injury as a result of medical treatment may be uninformed of points of law; and

Whereas, H.B. 1460 provides that the Medical Review Panel consider evidence in "written form only," largely consisting of medical records of the usual type, which, in most instances, should provide the panel with adequate information to decide if the evidence in the claim does or does not support the conclusion that the defendant or defendants failed to meet the applicable standard of care as charged in the complaint or, in other words, to decide if malpractice does or does not exist; and

Whereas, Patient-plaintiffs with obviously valid claims are not well served by the requirement that they elect to pay the attorney on a per diem or contingency fee basis at the time of employment; now, therefore, be it

Resolved, That ISMA Board of Trustees seek to introduce legislation to postpone such a determination until after the Medical Review Panel has met, reviewed available information and indicated if there is an obviously valid claim.

A financial contribution has been received from Parke, Davis & Company, Merck Sharp & Dohme, A. H. Robins Company and Geigy Pharmaceuticals to assist with the educational program at the 1975 Convention.

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Kaolin	6.0 g.
Pectin	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine	
hydrobromide	0.0065 mg.
Powdered opium, USP	24.0 mg.
(equivalent to paregoric 6 ml.)	
(warning: may be habit forming)	
Sodium benzoate	60.0 mg.
(preservative)	

Alcohol, 5%

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Each 5 ml teaspoonful contains:

Guaifenesin, NF. 100 mg
Codeine Phosphate, USP. 10.0 mg
(warning: may be habit forming)
Alcohol, 3.5%

Non narcotic for 6-8-hr. cough control

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Each 5 ml teaspoonful contains:

Guaifenesin, NF. 100 mg
Dextromethorphan Hydrobromide, NF. 15 mg
Alcohol, 1.4%

Decongests nasal passages and sinus openings as it helps relieve coughs

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Each 5 ml teaspoonful contains:

Guaifenesin, NF. 100 mg
Pseudoephedrine** Hydrochloride, NF. 30 mg
Alcohol, 1.4%

**Formerly contained Phenylephrine Hydrochloride 10 mg

Decongestant action helps control cough and clear stuffy nose and sinuses. Non narcotic.

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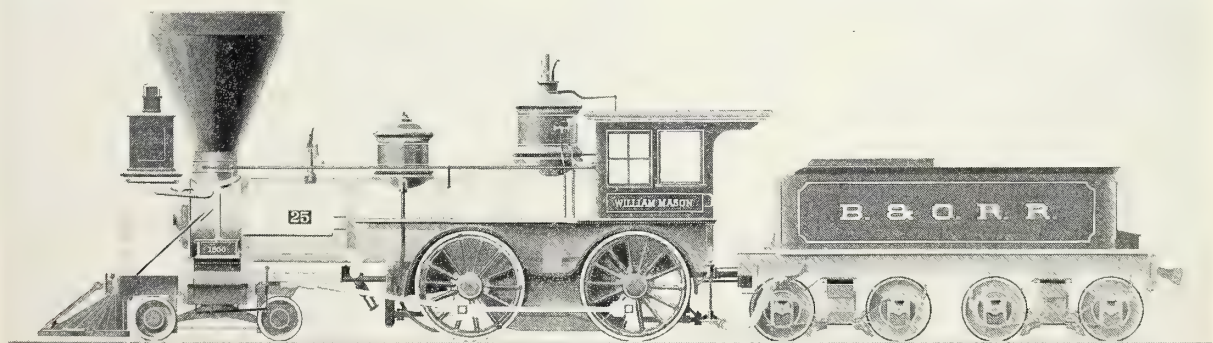
Each 5 ml teaspoonful contains:

Guaifenesin, NF. 50 mg
Phenylpropanolamine Hydrochloride, NF. 12.5 mg
Dextromethorphan Hydrobromide, NF. 10 mg
Alcohol, 1.4%

All Robitussin formulations available on your Rx or Recommendation.

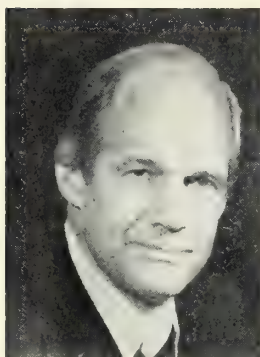
A. H. Robins Company, Richmond, Va. 23220 **A-H-ROBINS**

For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines. In keeping with this tradition, the company recently commissioned a well-known illustrator to render full-color drawings of several classic locomotives... accurate to the minutest detail. The first of the series is now available. To order your print suitable for framing, write "Robitussin Clear-Tract Engine #1" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



The William Mason (1856)

President's Page



It has not been the practice of outgoing presidents to use the "President's Page" to bid farewell. However, when I assumed this office one year ago I did so with a great desire for, and a fervent plea for "teamwork." Now I need to and want to publicly acknowledge that my desire and plea were not in vain, but were answered and supported enthusiastically.

From many sources did I receive significant contributions, incentive, encouragement and effort. I haven't the space to honor them all, but in particular I want to call attention to the staff of the home office in Indianapolis, members of the Board of Trustees, members of the many committees and commissions, the Medical Auxiliary, my colleagues in the medical profession and this Association, and the citizens of Indiana for their understanding and appreciation of what we have done for them and for their cooperation in those efforts.

I wish to share with you, on this, my final page, one of the many vivid and memorable impressions I carry with me from the presidency. As many of you know, I have traveled coast-to-coast and have been visited by physicians and politicians from both coasts in connection with our efforts toward malpractice legislation, a proposal of which I am proud to be an architect. I am doubly proud that my travels and visitors have revealed that our state is respected as a leader in the field of medicine for our accomplishments, the least of which is not malpractice legislation.

Therefore, I use these last lines to salute those who are responsible for the teamwork and for the respect we now receive—my Association and all the many dedicated physicians and citizens who endeavor to keep Indiana in her leadership role in medicine.

A handwritten signature in dark ink, appearing to read "Gilbert M. Wilhelmus". The signature is fluid and cursive, with a long horizontal line extending to the left.

Gilbert M. Wilhelmus, M. D.
President
Indiana State Medical Association

Association News

BOARD OF TRUSTEES

Sunday, May 4, 1975

Dr. Richard Ingram, chairman of the Board, called the meeting to order at 9 a.m. in the headquarters office.

ROLL CALL

Dist. Trustee

1	Bernard B. Rosenblatt	Absent
2	Paul W. Holtzman	Present
3	Eli Goodman	Present
4	Howard C. Jackson	Present
5	Cleon M. Schauwecker	Present
6	Paul M. Inlow	Present
7	John O. Butler	Present
7	Joseph F. Ferrara	Present
8	Richard G. Ingram	Present
9	William M. Sholty	Present
10	Martin J. O'Neill	Present
11	James A. Harshman	Present
12	Alvin J. Haley	Present
13	G. Beach Gattman	Present

Dist. Alternate

1	E. DeVerre Gourieux	Present
2	Edgar R. Cantwell	Present
3	Thomas A. Neathamer	Present
4	William F. Blaisdell	Present
5	William G. Bannon	Present
6	Glen Ward Lee	Present
7	Donald C. McCallum	Present
7	John G. Pantzer	Present
8	Jack L. Alexander	Absent
9	Max N. Hoffman	Absent
10	Leonard W. Neal	Present
11	Lloyd L. Hill	Absent
12	Franklin A. Bryan	Present
13	Donald S. Chamberlain	Present

Officers/Executive Committee

	Gilbert M. Wilhelmus	Present
	Vincent J. Santare	Present
	Hugh K. Thatcher, Jr.	Present
	Arvine G. Popplewell	Present
	Frank B. Ramsey	Present
	Joe Dukes	Present
	John W. Beeler	Present
	William R. Cast	Present
	Donald M. Kerr	Absent
	William R. Clark	Present

Guests

	Patrick J. V. Corcoran	Present
	Robert Yoho	Present
	George Haley	Present
	William J. Davey	Present
	Malcolm O. Scamahorn	Present
	William F. Paynter	Present
	Harold W. Hefner	Present
	Terry Brown	Present
	Steven C. Beering	Present

Staff

	Robert J. Amick	Present
	Kenneth W. Bush	Present
	Howard Grindstaff	Present
	Bob Sullivan	Present
	James Waggener	Present

Chairman Ingram: We have a quorum so will proceed with the business of the

day. We have a large agenda. I have started a new idea, as you may have noticed in your agenda, that we review very quickly what has taken place concerning your actions of the prior Board meeting each time. I'll tell these very quickly so if you have any questions, stop me.

RESOLUTION 68-20B—Insurance Driver Examination Form

The resolution has again been distributed to the membership. A letter was sent to the Insurance Commissioner and to the insurance carriers.

HRJ 6

Called for the deletion of the office of coroner from the Constitution. This died in committee.

TEL-MED FINANCING

The Chair appointed Drs. Sholty, Inlow and Jackson and Mr. Waggener to investigate alternate ways of financing this operation. Dr. Sholty and his committee have worked hard on this but with little success. We have been promised \$30,000 from Blue Shield, and a request has been made to RMP for \$65,000 to fund this until December 31 of this year. Mr. Waggener says that he has had a call from the Blues and that the money is on its way for Tel-Med.

NOMINATION OF DR. DON WOOD to the Judicial Council of AMA

This is a presidential appointment and a letter has been directed to Dr. Parrott recommending consideration of Dr. Wood.

LETTER TO AMA PRESIDENT TODD

Letter expressed the Board's compliments to the AMA for filing suit against HEW to enjoin them from enforcing their certification regulations.

HEALTH SERVICE AREAS

A letter, copy to Dr. William Paynter, State Health Commissioner, has been sent to the Governor setting forth the Board's feeling on the establishment of the health service areas.

OBJECTIONS TO JCAH MANDATE

Letter voicing our objections has been mailed to Dr. Sprague Gardiner and to the Board of Commissioners of JCAH in regard to their mandate of August 1974 requiring one outcome audit per month per major service to become effective July 1976.

MINUTES OF THE MARCH 9, 1975, MEETING

Approval of minutes was moved by Dr. Ferrara, seconded by Dr. Schauwecker, voted on and carried.

TEXAS STATEMENT—PSRO

Chairman Ingram: First of all, there was a motion by Dr. Harshman, seconded by Dr. Schauwecker, that we adopt the Texas statement regarding

PSRO. It was tabled until this meeting by motion of Dr. Ferrara. Do I hear a motion to bring it from the table, or table it further?

It was moved and seconded to return this motion for discussion. The motion passed.

Chairman Ingram: In your minutes, on page 16, is the discussion. The policy states: "It shall be the policy of the Texas Medical Association that the expenses of conducting a utilization review program shall be borne by the company or agencies which require a review. Physicians who work regularly in the utilization review capacity shall be appropriately compensated for their services. Non-physicians or professionals who work in a review capacity will be responsible to and shall be directed by the physician. Texas State Medical Association feels that it will best serve interests of the public, patients, and medical profession if physicians will lend experience and their expertise to the development and management of the systems designed in which the medical statistical data will be fed. TMA recognizes that utilization review is an institution-based activity in which law and regulations require that certain conditions must be met before reimbursements may be made. The responsibility for meeting the requirements rests with the individual hospital using their own facilities." The motion that was tabled is that we adopt the Texas statement. We've brought that back; we are now discussing the motion to adopt the Texas statement.

Dr. Holtzman: This might well be tabled until Dr. Dukes gets here. He has further information on this and he is coming. He was at the review PSRO meeting on Thursday.

Dr. Harshman: I move a temporary postponement of the item until Dr. Dukes gets here.

Motion was seconded and carried. During the afternoon session Chairman Ingram brought to the attention of the Board the Texas Medical Association's statement regarding PSRO.

Chairman Ingram: Dr. Dukes, we had a motion this morning that was postponed temporarily until you returned, concerning adoption of the Texas Medical Association's stand regarding PSRO. Dr. Holtzman told us you have a lot of information to bring to us concerning that. We first need a motion to bring the matter from the table.

It was moved by Dr. Schauwecker, seconded by Dr. Gattman and passed to bring the motion from the table.

Dr. Dukes: I don't really have anything to comment on. I did talk to Chicago and went through their offices. I don't think their left hand knows what their right hand is doing. I don't think anything is going to happen too quickly. They're going slowly. As far as I'm concerned, I would do nothing; but I

see nothing wrong with the Texas statement.

There followed much pro and con discussion on the Texas resolution.

Dr. Jackson: Did we incorporate the suggestion of Dr. Thatcher that we delete the Texas Medical Association and put ISMA in there?

Chairman Ingram: No decision was made. I had made a statement that I felt the original motion states we adopt that policy. It would be an approval of the verbiage and not the fact that it's Texas Medical Association. I don't think that means anything. The question has been moved—the question being that we accept the TMA policy, the one I read to you; and for clarity's sake, it would not refer to Texas at all but just the policy. Is there a second to the motion of the question?

The motion for the question was seconded and passed. A vote was taken on the motion to adopt the Texas resolution. It carried by 12 to 4.

TEL-MED FINANCING

Chairman Ingram: There was a motion by Dr. Sholty to have the executive secretary write a letter to all members asking for volunteer funds for Tel-Med. The motion was tabled until May 4. Do you wish to take action on it?

Dr. Sholty: Dr. Ramsey had an article in *The Journal* which says essentially the same thing.

Chairman Ingram: If there is no motion, it will just die. That ends the matter.

GREAT LAKES CONFERENCE

Chairman Ingram: If you recall, I brought this up several times—the idea of getting together some of the neighboring states on an informal basis to discuss our problems concerning the malpractice crises and was asked to put this off because of our own pending legislation. Our legislation is, as we've been told by several important people, the landmark legislation, and we've also taken the stand that the states solve their own problems, rather than the federal government doing it; however, perhaps we could offer some guidance to our neighboring states.

Dr. Wilhelmus: Dr. Ingram, I would like to make a suggestion here. I think at the present moment we have not had a county officers' conference this year and if I can work it out, I might have a county society officers' program and bring in all the presidents of the states around.

Chairman Ingram: That's excellent. Save a lot of money too. That would accomplish what I wanted to do. With the permission of the Board I'll just delete that from the agenda unless someone wants to do something about it.

PRESIDENT'S REPORT

President Wilhelmus: I went to Goshen, Elkhart County, for the ISMA Auxil-

iary meeting. The convention was a dynamic success. There was the largest crowd at an Auxiliary meeting for many, many years.

Went to Wisconsin for their convention. Gentlemen, it's a pleasure to be from Indiana. They have problems greater than our problems. They have a governor who's a realtor, who's anti-medicine. The governor gave an executive order and froze all health care provider fees on Medicare and Medicaid patients and he is attempting to do this on private patients. The state association is taking it to court and it looks like it will be a lengthy legal battle. They don't know what's going to come out of it.

We, the executive committee, were in Washington, D. C., this past week. There are a lot of new, young faces in Washington, particularly from Indiana—a lot of new, young Democrats. My feeling was that these men are not as liberal as most of us felt they would be. They all did not like Kennedy's program. I had a letter from Birch Bayh and his administrative assistant and they are all asking for input on which way to go. I think we're going to have to start getting more communication between our congressmen in Washington.

I've had a lot of comments, particularly on the President's Page on "confidentiality." I've had numerous letters and phone calls. I received a letter from JCAH in Chicago. I would like to read a couple of paragraphs from it concerning Performance Evaluation Procedure (PEP). "Dear Dr. Wilhelmus: Attention has been directed to the President's Page of your association's journal where you discuss the creation of an ad hoc committee to concentrate on JCAH Performance Evaluation Procedure. Speaking for the Joint Commission, I am most pleased to see such a step being taken. We certainly stand ready to provide any information the district committee may require." Continuing, "... and should the committee be able to visit our Chicago headquarters, we would be pleased to present a seminar."

I'm in the process of appointing a committee. I've had a chairman for quite some time. This committee could follow through, digest the material and disseminate it to us, to keep us informed on what is really going on.

The Medical Practice Act went through the House and Senate and the Governor signed it a week to ten days ago. So we do have a new Medical Practice Act. I want to thank Dr. Bryan who made a great effort.

The second piece of legislation had us quite upset. Some of the legislators put a bill through which would allow a foreign graduate medical student or a foreign graduate to come to the state of Indiana without taking the same examination that the Indiana University medical students have to take to practice in

the state of Indiana. They could come here after two years of preceptorship with any health care provider and would automatically be given full licensure by the state of Indiana to practice medicine wherever they desire in Indiana.

Dr. Wilhelmus then described in minute detail the effort and teamwork that it had taken to pass H. B. 1460.

Dr. Harshman: I understand that the bill (1460) won't be printed in its entirety until the next month's issue of *The Journal*. That will be very widely read. I would hope perhaps there would be some paragraphs of explanation with it. It might clarify some points, rather than just print a rather unreadable legal document.

Mr. Waggener: I want to explain we have a memorandum of clarification out to all the presidents and secretaries of county medical societies, hoping they would bring this to the attention of the society.

Chairman Ingram: I would like to ask Mr. Waggener if in the very next News Flash he would lay this out for us, one, two, three, four, because people do read that—tell them what it covers and when it covers it, according to the law. If it takes further legal consultation, I personally believe we should get it. We spent a lot of money, and we don't want to get some doctor's "toe in the crack" when we've been trying to help him.

Dr. Ferrara: When you send material to the president of the medical society, that does not necessarily get out to all the doctors. I would move that we send a letter out to each doctor in the next few days.

Chairman Ingram: We have a motion to send an explanatory letter to every member in the next several days. Is there a second?

President Wilhelmus: I second.

There followed much additional discussion on procedures in communicating the facts of 1460 to the membership.

Dr. McCallum: I think we need more than an explanation to this bill. I think we need to recommend. I think our membership really deserves recommendations from this Board on what to do about coverage—whether to keep their umbrella or not.

Chairman Ingram: That's a reasonable sort of request. Apply it to the motion.

Dr. Ferrara: Add that to the motion.

Chairman Ingram: . . . with the statement until the constitutionality has been tested. I have a second. Do you understand the motion? As stated, it would be that a letter will be put out to every member of ISMA. That letter is to explain the points of the law in these areas we've discussed and recommending now—that they keep their umbrella until this is shaken out. Now we've had discussion contrary to this, but that's the motion. Does everyone understand that?

The Chair is going to divide it, and we're going to vote on two motions. The first one is—we send a letter to the entirety of the membership explaining the points of the law clearly.

A vote was taken on this portion of the divided motion and it passed.

Chairman Ingram: Now we're voting on the second half of the divided question—whether to make recommendations specifically to the membership concerning the maintenance of, or non-maintenance of their umbrella.

This portion of the divided question was voted on and was defeated.

REPORT OF THE LOBBY COMMITTEE

Chairman Ingram then called on Dr. William Cast, co-chairman of the Lobby Committee.

Dr. Cast: To begin, back in October we were very fortunate with our timing. It was just a blessing we did it when we did. To say a word about the organization. After the basic decisions are made and the organization comes into being, unfortunately, the best way to deal with the legislature and with a single issue, depends on the issue. But with an issue like this, things have to be very tight, as far as organization, and in a way, undemocratic. When you are dealing with a changing piece of legislation, and they come with changes in language, you can't have six or eight people commenting on it. The committee can agree but there has to be one man to do the dealing. That is not the way doctors like to do things, unfortunately. The communications we used were various kinds of lists and phone lists.

Dr. Cast then reported in detail to the Board, as the official report of the committee, the structure of organization, and the methods utilized to pass 1460.

REPORT OF MR. WILLIAM DAVEY

Mr. Davey: In view of the passage of H. B. 1460, Medical Protective is going to write new business. I can't tell you how much business will be written but certainly we are going to concentrate on new fellows coming out of medical school and the doctors who will join the partnerships and professional corporations that we have. One thing important to understand is that Medical Protective is under the gun in 16 states. I am probably the most optimistic individual in the industry, as a result of the passage of this bill. As far as any real benefits, I think we have to project two or three years down the road. A few moments ago, the question was asked in regard to the risk manager. Right now they don't know who the risk manager is going to be. We do have reason to believe it will be Medical Protective although I understand there have been a couple of other proposals submitted. Insofar as the policy that will be used, it will be an occurrence policy, the Medical Pro-

TECTIVE policy. One of the interesting things to come out of the discussion with the Commissioner was his reluctance to approve a claims-made policy. At this point I don't think he knows what he's going to do. My personal opinion is, even though I'm not an advocate of the claims-made policy, that it should be approved. The principal reason I say that is St. Paul insures roughly 1,000 doctors in the state. Mel Mosely tells me 1,000; the commissioner told me 850. Now, in the event the insurance department disapproved the claims-made policy, St. Paul has made it clear they will cease operating in the state of Indiana. What does that mean? That means we have a thousand doctors immediately coming into the residual market.

Mr. Davey then continued with a detailed report on the policies of his company and the future outlook for insurance in Indiana.

REPORT OF MEDICAL SCHOOL DEAN

Dr. Beering: Our class at this point is 286 individuals, and we do intend to admit a full 305 for the class beginning in August. The students are coming this year from an applicant pool of 1,775 individuals—812 are Hoosiers—and the 286 thus far include only two out-of-state people who happen to have close relationships here and are technically out-of-staters. Although not legally required, we are on record to give preference to our own people. The average of this class coming in thus far is 3.66, which is just a shade above last year. Over two thirds of all our students now are receiving student aid of one form or another. It costs the average medical student in our system \$5,700 a year to maintain going to school. Being married costs a little bit more. The actual outlay is in the neighborhood of six or seven thousand dollars for the majority of our students. Tuition represents \$1,000 of this figure; and as you know, we made a valiant effort, despite federal urging and severe pressure, to maintain tuition where it is. Of about 260 graduates this year, we are retaining 60% in Indiana, which is a new high, both in percentage and in actual numbers, because it's the largest class yet. Another 11% will be doing their residency in cities immediately adjacent to Indiana.

Dr. Beering discussed a number of additional points pertaining to the I. U. Medical School and answered innumerable questions of the Board.

REPORT OF DR. POPPLEWELL ON HEALTH SERVICE AREA DESIGNATIONS

Dr. Popplewell: You should all have the handout dated March 20 which, essentially, reports the activity of the committee. You'll find our position is that we had one major goal—that was to keep

Indiana intact so we didn't lose Floyd County, Dearborn, and Ohio counties. The report shows what we actually had recommended this at a meeting at the State Board of Health. I think in all cases CHP agencies have been active in trying to promote their agency and becoming the area representative, as well as some of the others. For instance, Health Service Management here in Indianapolis, even before we officially were participating in the area designation, was already talking about our area, in terms of their planning. Some of the CHP agencies, as I understand, are not too close to organized medicine in our areas. Your committee promoted the five-area map but, after talking with the members here and at their last board meeting, did not oppose the recommendations Dr. Paynter would be making to the Governor. It was obvious from the beginning that Dr. Paynter's staff was promoting the three-area map. We wouldn't oppose this providing they maintain the idea of subregions and the concept that there would have to be significant physician input in all areas of the state to make this thing go. Dr. Paynter is committed to these ideas.

Dr. Paynter then was asked numerous questions by members of the Board.

Dr. Harshman: I think your staff did as well as it could in drawing the lines. My question concerns the setting up of the HSA. How is this going to be accomplished?

Dr. Paynter: Let me back up and make a couple of comments to put it in perspective. It's clear at the present time that this particular law 93-641 was put into place for one reason—that the federal government's experience in federal health dollars for services have been, as they see it, catastrophically expensive. In contemplating national health insurance, with the wisdom of committees important in the work along these lines, they must have a controlling feature to help delivery system prior to national health insurance. The law is labeled Health Planning Resources and Development Act of 1974. It's really a regulatory law, using the vehicle of planning as a mechanism for regulation. I'll try to answer your questions specifically. First of all, we do not at the moment have any crystal clear idea on how these agencies will be put together. My understanding is that the undertaking for organization and identification of those agencies will be kept in the hands of the federal government, and the regional offices of HEW will assume this activity. They are supposed to give us some regulations and guidelines by September of this year.

Dr. Corcoran: I'd like to tell the group that Vanderburgh County has taken a very vigorous dissent from this decision, as you probably know. It's based on experience we've had in operational

health planning organization for some years. We were not even able to get 11 counties together. We're concerned with the size of these areas, that the physicians in practice will not be able to take the time to travel to meetings, and people will be nominated by full-time, salaried individuals who will have vested interests and will go there.

Dr. Paynter: The part of the law that will, I think, assist in this matter is that part that states there may be sub-area councils. It is, as Dr. Poppelwell has indicated, within the law that the large area will, if it chooses to do that, divide itself into sub-areas. It would seem very logical to me that if there will be three or four sub-areas in the southern part of the state, for instance, generally in the Evansville area, another in the New Albany-Clarksville-Jeffersonville area, another in the Bloomington-Columbus area, and one in the Terre Haute area, this will provide a council with physician representation in that area, which probably will require less travel than you now have under your current arrangement. There will be regulations, but it's in the statute.

Dr. Paynter went on to answer additional questions on the HSA.

Dr. Harshman: I think all of us recognize the importance of the bill and its potential, but we're rather concerned about the composition of the governing body here, the HSA.

Dr. Paynter: I'll be very clear about what I think ought to happen. I think this association ought to be a point leader, starting now. I think the Medical Association should gather in a place, your leadership, this group, the Hospital Association, and other professional associations as one would choose to bring together. I would even think about expanding into groups like Commerce, Farm Bureau, and other interested groups that are bound to become involved in health care delivery. I think those groups with a great deal of professionalism, literally the operators of the health care delivery system, ought to begin the development of strategy and shape as they see it should be—the control of those agencies.

REPORT OF LEGISLATIVE COMMISSION CHAIRMAN

Dr. Scamahorn: As you know, the Commission on Legislation took care of legislative matters other than malpractice. We did pass H.B. 1698, which is the Medical Practice Bill. The portion in regard to the physician assistant was taken out of it before it was introduced. The last problem was the Senate Conference Committee on Senate Bill 111, which was going to bring any doctor in by reciprocity. It was vetoed by Governor Bowen; so when you see the Governor, thank him for his very honest and rather strong stand. The chiropractors

again were in on a request. They want full x-ray and lab permits, the same as all general practitioners. Basically, we got done what we wanted to do. I would caution on dividing our legislative program between two committees. I think this caused us some trouble and it made it uncomfortable for my commission. I want to say the Auxiliary did a fantastic job and were extremely helpful. The three representatives—Coleman, Pizzo, and Lamkin—were at every meeting except one. We listened to them; they listened to us; and I think this was very worthwhile.

I have a copy of the contract that we are going to approach the officers of the Indiana National Bank with to perhaps consider a change in our student loan fund. It is very similar to the AMA-ERF. I found that other states are doing it.

REPORT OF PRESIDENT-ELECT

Dr. Santare: We lost a past president of the State Medical Association, and I think his entire life, as long as I've known him, has been devoted to ISMA. Whatever he did was for ISMA, and he died this year. The entire staff showed up at the funeral home. With the chairman's permission, I'd like a minute of silence for K. O. Neumann.

The Board stood for a minute of silence.

Dr. Santare: We sent a committee to Las Vegas; Dr. Ingram and I went. This was a meeting of the AMA and the American Bar Association. We were outnumbered at the meeting. There were two lawyers to one physician. At that particular time we were for a compensation board. One of the things we found out at that particular meeting was that the attorneys who were there (not famous attorneys just hospital attorneys, medical society attorneys) felt that a screening committee with teeth and the type of law we actually produced would be the best thing for us.

In our particular area where we do cross state lines, we have told our particular people that we are not covering you with our law. You are going to have to be very careful when your patients come in. If you're going to give information, or you want to advise a patient, have them come over on the Indiana side of the line. You can be responsible if you do anything across the state line. Once you go to a federal court, you're not covered by our particular bill.

I want to compliment our president concerning the Washington trip. He really has a good brain for organization. He got us there when we were supposed to be there. We had our duties outlined. We were able to do what we were supposed to do and we accomplished it. We did meet with Dr. Egeberg—Dr. Wilhelmus, Dr. Ingram, Mr. Waggner and I. As far as malpractice is concerned, our president thanked him for coming to Indiana and giving us help in getting

our bill passed. As far as the national thing is concerned, he felt the Hastings Bill would be necessary in some states, and he particularly mentioned California, New York, Florida, and Michigan as having problems and they may not get their problems settled through their state legislatures.

Chairman Ingram: Dr. Egeberg said that any state that did have its problem solved would be in no way mandated to participate in the federal program. So that was a little refreshing, in that he thought the states should solve their own problems. This is the same attitude in every congressman's office and in both of our senator's offices—that they wanted the states to solve their problems.

Dr. Santare: I would also like to thank the staff for setting it up. We had a dinner with the legislators from Indiana. We had about 75% attendance. Those who couldn't come sent their regrets and said they enjoyed the meetings. One thing we did learn is that our legislators, whether Democrats or Republican, are quite apprehensive about what is going to happen. They are afraid of continued inflation; on the other hand, they are afraid of recession since it might go into depression.

One of the things we did learn from the AMA staff concerns the bill on health manpower. It's a very serious and dangerous bill. In the proposed legislation, Indiana needs \$5.6 million from the federal government for per-capitation support. They are going to lose 30% of it this year. For that money which is given to the medical school, this particular bill requires that each student who receives the capitation money (he doesn't receive it, his school receives the per capitation money) is now obligated to do either of two things—pay it back, or serve in some area, year for year, for each year that he received capitation from the government to serve in some area where the secretary of HEW tells him to go. This, I think, is very dangerous; our AMA is fighting it. They advise us to speak to legislators against this thing.

Dr. Santare: I did attend a meeting in Indianapolis at the request of Dr. Wilhelmus, who couldn't make it. This meeting was with the Health Services Management. They have a grant in which Health Services Management, the B agencies, the Blues, and the Health Department are involved; and it is now being funded (75% from RMP and 25% from Blue Shield) to do a doctor census in the state of Indiana. The census will be done by the telephone book, the AMA directory, the State Medical directory, and perhaps by calling some physicians in local chambers of commerce. They have the money; they have the personnel; they're going ahead to do it. The idea in doing this is for prospective health planning. My question was, are they going to

get the information before any other health provider in the state? They said, no, the information would come back to this particular committee and it would determine how it would be set up after that.

Dr. Holtzman: What is Health Services Management?

Dr. Santare: Health Services Management is an organization that was set up in Indianapolis to do some planning for their B agencies. They are funded on a RMP grant, as I understand, and they are to obtain information and give some direction to the B agencies in Indiana.

Dr. Popplewell: They were originally set up as an agency to carry out the responsibilities that originally were given to CHP. We have one here in Marion County. They set up this kind of an agency specified to do about five things, including funding of a nurse practitioner program, a pediatric nurse practitioner program; and there were three other things that were set up. We imported a young man from Washington as the executive. The agency did nothing that it was contracted for other than to do the practitioner's program and they proceeded to do it in other studies with the primary goal of trying to impact on the practice of health care. The most successful ventures have been in the area of maternal and child health, where they have been able to get some of the obstetricians together and get an agreement on a program within Marion County. It's a county organization, to try to reduce maternal and child morbidity. Now this agency for a period of time was spending primarily federal dollars. As the money started to run out, they sought other revenue. Part of that has been RMP money. They have also been out in other areas of the state to do certain studies. I think all this information, basically, is available already. There's \$100,000 sunk into this project. I have to admit some prejudice about this project. I was on the evaluation committee that evaluated this. Six months after the grant had been provided through RMP, nothing had been done.

Dr. Santare: I did call the Governor. He was very courteous. He said he had referred HSA to Dr. Paynter. I did speak to Dr. Paynter and he gave me the arguments which you heard today. One other which I didn't hear him mention and which I heard in Washington, was that all HEW is going to recognize is 200 areas within the entire country. With 200 areas within the entire country, Indiana would be doing very well to get three. I called a meeting in the northern band of the state, and we had representatives across the northern band of the state. Unfortunately, Dr. Haley wasn't there, but the other trustees from the other two areas were. We set up a group to start it. Dr. Gordon Cook is president of the South Bend Medical Society and

is the chairman of the organization. He has a steering committee. We're starting with doctors. We're going to set up a corporation. We will invite the other health providers and hospitals and any other groups we feel necessary. We will apply for the HSA grant in northern Indiana. The reason we will apply for it is because it will include Hill-Burton; it will include certificate of need; it might even include doctors' offices, etc. in that particular law, so that if someone has control of this, they have good control of the practice of medicine in the area. We received a solicitation from SSA which states they are offering the State Medical Association the option of collecting some data to go to Social Security for their particular use. They didn't tell us what this use is, but they would like us to find out about prevailing charges, physicians' fees, physicians' specialties in the area. The government is asking to give us the money, to give them some information. I would recommend, if you would accept my recommendation without my going further, that we do not apply for it.

Chairman Ingram: There's a motion by Dr. Thatcher, seconded by Dr. O'Neill, that we do not participate in this. Is there discussion?

Following a brief discussion on the motion, it was put to a vote and carried. Dr. Santare then related an experience with the county coroner in northern Indiana and expressed the thought that the ISMA should press for a change in the medical examiner system next year.

REMARKS OF DR. CORCORAN

Dr. Corcoran. The matter of relicensure and, related to it, recertification, which I think does apply to every practitioner, is effective in the near future and I think this has not really been recognized. As you know, I was chairman of the committee on maintaining continuing competence of the AMA, and we wrote a series of three reports on how we felt this should be done. Related to that, I ended up as chairman of the committee which was dealing with the formulation of a uniform code of state licensure, in conjunction with the national commissioners of uniform state laws. I feel very much frustrated because all of this has been in the plan for more than half a year now, with the fiscal restraint of the AMA. We were deeply concerned because a good many people are pushing, and nobody seems to be working very actively to hold back and review the implications of relicensure and recertification. Now, recertification is already a matter of fact with two of the boards—the American Board of Family Practice and the American Board of Internal Medicine. Four states have relicensure presently as a matter of law; two others are in the process of implementing it. The relicensure itself may

also go to a challenging examination.

Dr. Corcoran: AMA, in trying to develop good means of peer review, asks how you measure the way a physician practices (which we regarded as the essence of whether or not one should be allowed to continue to practice). At the present time, I don't think many states are going to refuse relicensure, but I'm not at all sure that federal relicensure couldn't be very easily accomplished. I must confess extreme frustration with the AMA in not working vigorously on these "gut" issues.

Dr. Gattman: Is there any way that Dr. Corcoran can give us a resolution that we can pass so as to ask what is going on?

Chairman Ingram: We can work something up and bring it back at the next meeting.

Dr. Corcoran: I think the delegation, Dr. Butler, Dr. Harshman and I, ought to be your agents and go back and prepare to ask a few hard questions. I am willing to do it. I don't see why we're having a meeting in Hawaii; it's cheaper to have a meeting in Chicago. Look what it is going to cost to send officers and staff.

Dr. Harshman: I concur with Dr. Corcoran. I think this is precisely why a committee was appointed, to hope to get to the bottom of some of the facts as to what is going on at headquarters. But unfortunately, those facts have not been made public to the House of Delegates. They've been privy to this group, and I assume they've been digesting them. I called Dr. Scamahorn on several occasions and I've had the same experience that Dr. Corcoran has had—that it was agreed upon by members of the committee that these matters would not be divulged to people outside the committee. I respect that commitment, except the day of reckoning is approaching very rapidly, and I would assume we are going to have a day of reckoning this June. I'm also prepared to ask many of the same questions that Dr. Corcoran is asking. I think we should be prepared to go to Atlantic City, not only to talk about malpractice, elections, etc., but also to be prepared to discuss some of the in-house problems in the AMA, which to me is the most important problem that we have.

Chairman Ingram: I'd like to comment at this point. We will have the AMA delegation here at the next meeting. It seems it's late to put a resolution into the AMA House with the expressions we have here.

Dr. Schauwecker: I would move that, since our delegates seem to agree there seems to be a requirement, to look into this and report back.

The motion was seconded by Dr. Santare.

Dr. Goodman: I move the motion be tabled until the Board meeting before the

Atlantic City meeting so that we may hear from the rest of the delegation.

The motion was seconded, voted upon and carried.

TREASURER'S REPORT

Dr. Gattman: I'd like to move we accept the treasurer's report as printed in the minutes.

Chairman Ingram: It's been moved and seconded that we accept this as printed in the minutes.

The motion was voted on and carried.

Dr. Thatcher: We have to draw your attention to one thing. You now have left in your own expense fund for travel—\$959.00. This goes until October. The thing I would bring to you is the Public Speakers Bureau account which has a balance as of May 2 of \$52,820 and we have drawn another check for \$840 on that just today. In regard to the expenses of the legislation, to date, including a check for some \$36,000 that we signed today, money spent in charges of the account of liability insurance special dues account was \$129,660.55, of which \$39,600 is covered by special assessment. A transfer of \$20,000 from last year's public speakers' account is a total income of \$59,600. Dr. Wilhelmus wasn't going to be able to be here, and he asked me to stress a point that they are going back to Dr. Wright. He's going to put out another letter to physicians to see who can contribute money, who did not contribute before, which could cut down our deficit here. However, we don't have that kind of money in our budget for the year, and it's going to have to come from some place during the year—\$70,000 deficit.

Dr. Harshman: I appreciate the figures because I know we spent a lot of money. Our assessment for the Speakers' Bureau was a two-year thing. That has expired. I think this Board ought to be prepared to present to the House of Delegates a resolution making up this \$70,000 which is going to be a continuation of the \$20,000 which has automatically expired. If we would keep that up for one more year, we would have raised the \$70,000 deficit. I can guarantee you'll have no problem in getting that kind of money, because the people in our area are grateful for what's been done. I'd like to move that the matter of the \$70,000 deficit spending we have become afflicted with these past few months be referred to the Board Committee on Economic and Fiscal Affairs so that they can review the financial situation and be prepared to come up with a resolution for the House of Delegates this fall, if we do, indeed, need additional dues money.

Dr. Santare: Second.

Motion passed.

Chairman Ingram: As a suggestion to your committee, Dr. Goodman, review the minutes of the reference committee as passed by the final actions of the

House which considered both of these items—the one over a two-year period; the other over a one-year period. We must be bound by the discussion at that time.

REPORT OF DR. SHOLTY

Dr. Sholty: The Medical Museum is really one of its kind; it is a real gem of a set-up out there. I think we should have a Board meeting there.

EXECUTIVE COMMITTEE

Chairman Ingram: I'm going to give the Executive Committee report. There should be a discussion as to whether or not the Board of Trustees would like to go back to the Inn of the Fourwinds for their meeting in August. Last year we did go there. Dr. Kerr needs to know if it's our desire to do that again. We made a flat allowance of \$50 per man. Dr. Kerr must know now.

Dr. Sholty: I move we have the August meeting at the Inn of the Fourwinds. The motion was seconded.

Chairman Ingram: Is there discussion on the motion? The motion did not include a limitation on expenses. Are you aware of that?

Dr. Gattman: Let's include that we have a \$50 maximum per man.

Chairman Ingram: Is this seconded? Those in favor say aye. The motion has been accepted as amended—that we have a meeting at the Fourwinds with a maximum expense of \$50 allowed each man.

Dr. Santare: I move that for this particular meeting we allow \$50 per man, plus mileage.

Dr. Goodman: I second.

Chairman Ingram: It has been moved to amend the amendment of the original motion to say \$50 plus mileage. Those in favor say aye. The motion carried with two negative votes.

Vote on the original motion as amended twice was taken and carried.

Chairman Ingram: Another matter is the request of the AMA delegation to be provided telephone credit cards for the use of calling other AMA delegates throughout the country. It is estimated there would probably not be more than 120-150 calls made. The Executive Committee referred this here. I think their feeling was that the Board should decide on this in concert with the expenses for the candidacy of Dr. Steen; therefore, I would like Dr. Harshman to make a comment. Basically, we discussed the candidacy and proposed campaign for Dr. Steen. One point that was made was there would have to be a lot of personal contact with delegates in the AMA.

Dr. Harshman then elaborated on the details of the planned campaign.

Dr. Harshman: In addition, we are going to have some other expenses. I thought I moved at the last Board meeting that we set aside \$3,000 for Dr. Steen's campaign, which would include the cost of mailing out letters to the

House of Delegates on two different occasions, plus telephoning, plus the extra hospitality room expenses. That's about all I can come up with at the moment. The use of this credit card was to allow members to call personally. That item would be no more than \$500.

Chairman Ingram: There was a motion by the Board to support Dr. Steen's candidacy. This passed unanimously, but there was no dollar figure with it.

Dr. Santare: I will now move that we support Dr. Steen's candidacy to the tune of \$3,000.

Motion was seconded.

Chairman Ingram: This does not speak to the telephone issue.

Dr. Thatcher: I would support the idea. I would request you consider carefully before you vote for this motion—the fact that this was not included in your budget. You are making an extra budgetary item at the present time. This was not even considered at the time the budget was made up. But with this and the credit card issue being as Dr. Harshman states perhaps as much as \$500, and we have no top capacity or control on that, I think we ought to consider it.

Following additional discussion, a vote was taken on the motion to support Dr. Steen's candidacy in the amount of \$3,000. This carried.

Chairman Ingram: It's been moved by Dr. Santare and seconded to allow credit cards.

Dr. Ferrara: The cheaper way to go would be to let them make their telephone calls on their own lines and then submit the bill, to dial direct.

Dr. Santare offered to withdraw his motion concerning credit cards, and this was accepted.

Dr. Goodman: I move the delegation be authorized to bill us for those calls.

Chairman Ingram: It has been moved and seconded that we let them bill us for their phone calls regarding Dr. Steen's candidacy.

The motion was put to a vote and carried.

REPORTS OF TRUSTEES

Dr. Gourieux: This Thursday evening we have our district meeting at Rolling Hills Country Club. We have a request from Dr. C. C. Young, Jr., President of the Southwestern Indiana Medical Review Organization, Inc., asking us for a letter of approval from ISMA for the above organization to apply for a planning contract to qualify as a conditionally designated PSRO for Indiana area status. They have recommendation letters from various organizations in the area.

Chairman Ingram: I believe that's contrary to the policy of ISMA and would not be forthcoming.

Dr. Chamberlain: In other words, what you are saying then is that the ISMA is opposed to PSRO?

Dr. Santare: I think I would agree with Dr. Chamberlain. The resolution says we would go along with it and work for the repeal of the obnoxious elements of PSRO. It did not say we were opposed to it, rather that we must work with it. Read the resolution.

Dr. Goodman: While we are waiting for the resolution, Mr. Chairman, let me also point out we also have the matter of the policy of, I believe, both the House and the Board to try to develop a viable alternative to PSRO.

Chairman Ingram: All right, we will come back to you, Dr. Gourieux.

Later Dr. Ingram returned the discussion to the First District request.

Chairman Ingram: This 74-19 was adopted. This resolution resolved that the Indiana State Medical Association join with the American Medical Association and other states in an effort to eliminate the objectionable features of P. L. 92-603 until such time as actual repeal is possible. Now I have one more here.

Dr. Harshman: 74-5 is on PSRO.

Chairman Ingram: 74-5 was not adopted. That was a negative one. Apparently the stance was, and this is the way I remember it, that we work to eliminate the objectionable features but continue to seek repeal.

Dr. Chamberlain: And, therefore, there is nothing ruling against our Association's acceptance of PSRO.

Chairman Ingram: We will go back to Dr. Gourieux to see if he has a suggestion. If there is a motion from the floor, I will accept it.

Dr. Gourieux: The executive secretary called me when I was leaving town. The medical society is working with Dr. Young on this group. It's the only one we have in that area.

Dr. Holtzman: Has your medical society discussed this?

Dr. Gourieux: Yes.

Dr. Schauwecker: Could I make a motion that this be postponed until our next meeting, at which time he can report back and give us the critique on Dr. Young and also the action of the medical society?

The motion was seconded, put to a vote and carried.

Chairman Ingram: Second District, Dr. Holtzman.

Dr. Holtzman: Second District meeting will be Tuesday, the 11th, at the Health Club in Vincennes, and I would ask that we have a remission of dues for a physician who has broken his hip and is no longer able to practice. I move his dues be remitted.

The motion was seconded, voted on and carried.

Dr. Goodman: The Third District meeting will be Sept. 13-14, which is a weekend, at the Marriott Inn in Clarks-ville. Featured will be the usual activities. I do have one problem. One of my

constituent societies, Floyd County Medical Society, with one hospital at New Albany, has firmly decided they will not take part in so-called concurrent and utilization review, no matter what. My own home society in Jeffersonville is going to vote on a similar thing, and I have reason to feel they will take the same action. I am being asked if this Board can help with the problem—the fact that these people are getting pressure from the hospital.

Chairman Ingram: They have an absolute right to do what they wish at the time, and their action does not preclude the hospital board from employing someone to do that job for them. Fourth District, Dr. Jackson.

Dr. Jackson: I have nothing further to report.

Chairman Ingram: Fifth District.

Dr. Schauwecker: Golf at 11 a.m.; business meeting at 4 p.m.; cocktails at 5:30 p.m.; dinner at 7 p.m.

Chairman Ingram: Sixth District

Dr. Inlow: Business meeting, Thurs., May 15. Scientific meeting. Golf at 10 a.m. I had a letter from the Fayette-Franklin County Medical Society asking for the remission of dues for a physician.

Motion was made, seconded and passed that the physician's dues be remitted.

Chairman Ingram: Seventh District.

Dr. Ferrara: Due to circumstances the meeting that was supposed to have been held in Martinsville, will be held at the Hillview Club in Franklin on May 14.

Dr. Butler: No report.

Chairman Ingram: Eighth District. I have a letter from the Madison County Medical Society requesting remission of dues for a physician because of a major stroke. We are also requesting that he become a hardship member.

Motion was made, seconded and carried.

Chairman Ingram: Ninth District.

Dr. Sholty: District meeting June 12 at Curtis Creek Club in Rensselaer. I have a letter regarding a physician and I would move his dues be remitted.

The motion received a second, was put to a vote and carried.

Dr. Sholty: I also have a resolution about Kenneth Neumann. I want to know if it was decided definitely to have Mrs. Neumann as our guest at French Lick?

Chairman Ingram: This is what I understand.

Dr. Sholty: Then I will inform her definitely of such.

Chairman Ingram: This is to be done at the President's Dinner, I think.

Chairman Ingram: District Ten.

Dr. O'Neill: The meeting will be held Sept. 24. I would like to recommend a reduction of dues for a physician. He has reached retirement age of 65 and according to law, his dues can be reduced to half the rate.

The motion was seconded and passed. Chairman Ingram: Eleventh District.

Dr. Harshman: Meeting Sept. 17 at Delphi. I was a guest at their last county society meeting. They have three Dunkard physicians in this area. They are first cousins to the Amish and Mennonites and meet in their homes. I've never had such royal treatment in all my life. I have a remission of dues from Wabash County.

It was moved that dues be remitted, seconded and carried.

Dr. Harshman: The other item is that I think we also have at least one county that will not go along with the utilization review regulation and will ask an outside group to come in and do it.

Chairman Ingram: Twelfth District.

Dr. Haley: I would move remission of dues for a physician-member of the Allen County Medical Society. He does have a health problem.

Motion was seconded and passed.

Chairman Ingram: Thirteenth District.

Dr. Gattman: No further report.

Mr. Waggener: You have a request, don't you, from St. Joe County?

Dr. Gattman: I did not get one. If you have one, I will be glad to present it.

Mr. Waggener: I have a note that they sent a letter to you. This came in from Rose Vance, secretary of the county society, to Dr. Gattman, asking for the remission of dues for a physician, a medical missionary.

Chairman Ingram: Will you move to that effect?

Dr. Gattman: I didn't get the letter from St. Joseph County regarding this but will move that we remit the dues.

The motion was seconded and carried.

UTILIZATION REVIEW P.R. PROGRAM

Chairman Ingram: New business. I have a few brief things here. The Indiana Hospital Association wants the respective staffs of ISMA and the Indiana Hospital Association to work out a public relations program on utilization review.

Mr. Waggener: They feel that the staffs should get together and formulate some sort of PR program to explain to the public as well as the profession the facts on utilization review. We should have, later, a conference of medical staffs and hospital administrators to explain utilization review. We feel that the educational aspects of this at this time are rather important.

Dr. Thatcher: I would move that the staffs of these organizations be permitted to investigate this.

Chairman Ingram: It has been moved and seconded that our staff be permitted with the staff of IHA to investigate this.

Dr. Goodman: Mr. Chairman, for a point of information concerning this motion. We are not in any way instructing our staff as to a position on this, are we?

Chairman Ingram: The motion is to investigate. I would think they would be absolutely bound to the actions of the House of Delegates and the policy established. Now then, Dr. Chamberlain, the information you wished to give.

Dr. Chamberlain: As you are aware, I am somewhat active in PSRO and I am rather amazed at the fact that there is so little discussion here about such an important item. I think eventually this will affect us all. The reason I am coming up with this is, it looks like the PSROs for this area, except for Lake County, will not be funded this year because there is no money. However, there is plenty of money for the Indiana Physicians Support Agency to operate PSROs for the state. There is a need to develop all the criteria and actually run it from the state organization and this is very bothersome from our particular area's point of view because we would like to run it ourselves and not have a state organization do it. It is also interesting; in fact, I would be willing to be corrected because there are many members on that board that are here today; the Indiana Physicians Support Agency has made several very interesting motions that I think this Board should be aware of. Number one, they have had considerable agreement with Dr. Paynter concerning the U.R. regulations. I would also point out that this central agency has also elected themselves and have nominated their board of directors to the State Professional Standards Review Council. It is this statewide council which will have the say-so over all of the areas of PSRO. It just bothers me to see the State Medical Association trying to completely ignore this, because these people have a lot of power, are going to have a lot of input into this, the U.R. rates, and into the state PSRO council. I should point out they also are getting representatives for this council now—from the Hospital Association and several other places. There is one spot on this council for a physician to represent ISMA. We have none at this time.

Chairman Ingram: I would ask that the discussion be confined to the motion.

Dr. Holtzman: I would like to speak against this motion. This is a government educational program. We have gone on record in our House of Delegates as working against, in every way, the implementation of PSRO. This is the hospital's problem in getting paid through government funds. I see no reason why the physicians should help educate. We have enough areas in PR which are more important, I believe, and this is a hospital-oriented problem.

Dr. Goodman: I would see nothing wrong with authorizing these two organizations to get together and consider the PR in this matter; however, we all agree that we are not going to authorize these people to take a position. The

position in my end of the state is that the hospital administrator in our area would like our help in letting the public understand why we will not, and I repeat, not, cooperate with this thing. They want our help in getting this across so that neither they nor we are hurt.

Chairman Ingram: The question has been moved. Is there a second? Those in favor of the question, signify by saying aye. Opposed, same sign. Those in favor of the motion to allow staff to investigate this matter? Motion passed.

OPPOSITION TO CLAIMS-MADE POLICIES

Dr. Ferrara: Because of the importance of claims-made policies and this can mean thousands of dollars to the physicians of this state and because Medical Protective, as we understood it today, will continue with their occurrence-type policy and will cover about 60% of this state, and also because, and this was confirmed this afternoon, there is one new company that was not writing malpractice liability insurance that was interested and was reaffirmed this afternoon by Dr. Wilhelmus that there are several other companies, I would move that this Board and the ISMA reiterate their opposition to claims-made policies and this information be sent to the Insurance Commissioner.

There were multiple seconds. There followed extensive pro-and-con discussion of the motion.

Dr. Goodman: I would move that this motion be tabled until after July 1, 1975.

The motion to table was seconded, put to a vote and passed.

LEARNING DISABILITIES CONFERENCE

Chairman Ingram: I have a couple of items which have been handed to me. This one from Thomas O. Middleton, M.D. is a letter to Dr. Wilhelmus. "I am including a resume of the enclosed conference on Indiana Rule S-1, on learning disabilities. We have received considerable support from government agencies in the way of administrative technical assistance. As you know, a conference entails additional considerable cost. We are asking some professional organizations around the state to defray these costs, and I am asking that the State Medical provide \$300, the balance to be returned to you after all expenses are settled." We did vote to send Dr. Middleton (vote by the Executive Committee), the registration fee being \$15.00, which was the entirety of the thing. He now writes asking \$300 and we need to take action on this.

Dr. Thatcher: I move we not accept.

Dr. Goodman: I second the motion.

The motion to not provide \$300 passed.

COMMITTEE ON SPORTS AND MEDICINE REQUEST

Chairman Ingram: The Committee on Sports and Medicine wants the authority to go to the Indiana State Board of Health to explore the possibility of getting a grant to establish a study program to establish athletic trainers in every high school in Indiana. This is a grant proposal.

Mr. Bush: The proposal was made by Pinky Newell, athletic trainer at Purdue University, and from an independent trainer from Chicago. They presented it at Dr. Brad Bomba's Sports and Medicine Committee meeting. They have been trying to get money through either a federal grant or from the Indiana University Foundation or through some Indiana foundation to put this plan into operation.

Dr. Goodman: I have it in the minutes of that committee meeting which was mailed to me a week ago.

Chairman Ingram: I think something of this magnitude requires that we see it in advance, that someone come and tell us what they have in mind. I think we should have this report made available to those in this room and have Dr. Anderson who signed this come and present it with a fiscal note. Would you take that back to them, Mr. Bush?

TEL-MED FINANCING

Dr. Sholty: I would like to bring up a comment again about Tel-Med. This is, I think, by far our best public relations program. It's still holding up with an average of about 800 calls per day. We are approaching one-third-of-a-million calls since the program started and it would cost each physician no more than \$25 per year. I think this is one of the best bits of public relations the doctor can put forth. This is being used by churches, schools and all sorts of organizations. Hospitals are giving each new admission a Tel-Med brochure. I think this Board should submit a resolution to the House of Delegates for a raise of \$25 dues specifically for supporting Tel-Med. I can't think of anything for which the doctors could spend \$25 more wisely.

Chairman Ingram: You have moved that this Board submit a resolution to the House of Delegates recommending a \$25 dues increase on an annual basis to support Tel-Med.

The motion was seconded. Discussion for and against the motion followed.

Chairman Ingram: The vote has been called. Hands raised for the motion. Five are for the motion. Opposed? Six are opposed. The motion fails.

NEXT MEETING

Chairman Ingram: The next meeting of the Board is June 8, 1975, at 9 a.m.

BOARD OF TRUSTEES

Sunday, June 8, 1975

Dr. Richard Ingram, chairman of the Board, called the meeting to order at 9:10 a.m. in the headquarters office.

ROLL CALL

Dist.	Trustee	
1	Bernard B. Rosenblatt	Present
2	Paul W. Holtzman	Present
3	Eli Goodman	Present
4	Howard C. Jackson	Present
5	Cleon M. Schauwecker	Present
6	Paul M. Inlow	Present
7	John O. Butler	Present
7	Joseph F. Ferrara	Present
8	Richard G. Ingram	Present
9	William M. Sholty	Present
10	Martin J. O'Neill	Present
11	James A. Harshman	Present
12	Alvin J. Haley	Present
13	G. Beach Gattman	Present

Dist.	Alternate	
1	E. DeVerre Gourieux	Absent
2	Edgar R. Cantwell	Absent
3	Thomas A. Neathamer	Present
4	William F. Blaisdell	Present
5	William G. Bannon	Absent
6	Glen Ward Lee	Present
7	Donald C. McCallum	Absent
7	John G. Pantzer	Present
8	Jack L. Alexander	Absent
9	Max N. Hoffman	Absent
10	Leonard W. Neal	Absent
11	Lloyd L. Hill	Absent
12	Franklin A. Bryan	Present
13	Donald S. Chamberlain	Present

Officers/Executive Committee

Gilbert M. Wilhelmus	Present
Vincent J. Santare	Absent
Hugh K. Thatcher, Jr.	Present
Arvine G. Popplewell	Present
Frank B. Ramsey	Present
Joe Dukes	Present
John W. Beeler	Absent
William R. Cast	Absent
Donald M. Kerr	Present
William R. Clark	Absent

AMA Delegates/Alternates

Patrick J.V. Corcoran	Present
Lowell H. Steen	Present
James A. Harshman	Present
John O. Butler	Present
Malcolm O. Scamahorn	Present
Thomas C. Tyrrell	Present
Peter R. Petrich	Present
George T. Lukemeyer	Absent
Ross L. Egger	Absent
Everett E. Bickers	Present

AMA Section Delegates

Joseph E. Walther	Present
Lall G. Montgomery	Absent
Frederic L. Schoen	Absent
Sprague H. Gardiner	Present
Myron H. Nourse	Absent

Guests

Harold Hefner	Present
Irvin Clampitt	Present

David Crane	Present
Carole Rust	Present
Tim Spencer	Present
Courtney Smith	Present
Staff	
Robert J. Amick	Present
Kenneth W. Bush	Present
Howard Grindstaf	Present
Bob Sullivan	Present
James Waggener	Present

BUSINESS FROM LAST BOARD MEETING

Chairman Ingram: We have a quorum. Once again, I've followed the program I started the last time to list what we did at the last Board meeting. The motion to include facts on H.B. 1460 in the News-flash has been done. A letter has been sent to all members of H.B. 1460. The motion to prepare a resolution to be presented to the AMA House of Delegates on relicensure and also on fiscal matters was tabled until this meeting so the AMA Delegation may express their opinions. The motion to refer to the Board Committee on Economic and Fiscal Matters the deficit created by our legislative program for a report as to whether this Board should recommend a dues increase was referred, and the committee will probably make a report at this meeting. Is that right, Dr. Goodman?

Dr. Goodman: Mr. Chairman, that committee will meet at noon today and report this afternoon.

Chairman Ingram: Fine. The request of First District Medical Society for a letter of approval for the Southwestern Medical Review Organization, Inc. to apply for a planning contract to qualify as a conditionally designated PSRO was tabled until this meeting. The plaque for Mrs. Neumann to be presented during the President's Dinner at the 1975 annual meeting—the copy is completed. The Board should direct the staff if this is to be hand-lettered and framed. Would you like to address that now?

Dr. Goodman: Mr. Chairman, I would move that this be hand-lettered and framed.

There were many seconds and the motion carried.

Dr. Sholty: I have talked with Mrs. Neumann personally, but I think a letter of invitation from this office should be forthcoming.

Chairman Ingram: This will be done. Now concerning the staff meeting with the Indiana Hospital Association regarding utilization review and health service areas, one meeting has been held. With court action on AMA's suit on utilization, no further action was recommended at this time other than to continue to watch and be prepared to institute a campaign if the need arises. Regarding health service areas, it was the opinion that the medical profession, the Hospital Association and other primary health groups should establish a joint committee for the purpose

of becoming a viable voice in the establishment of these organizations. The secretary has directed a letter to the president, president-elect and chairman of the board on this subject.

ISMA opposition to claims-made insurance was tabled until after July 1. ISMA has received \$25,000 from Blue Shield for Tel-Med. No additional funds have been received. Then, we have a letter from the Welfare Department on sterilization. Why don't we dispense with that right at the moment? No action on it now. If anyone has anything to say about it, we can cover it in new business then.

MINUTES OF MAY 4 MEETING

Chairman Ingram: Next item is the minutes of the meeting held May 4, 1975.

Dr. Gattman: I would move the minutes be approved as mailed.

The motion was seconded, put to a vote and carried.

FIRST DISTRICT PSRO

Chairman Ingram: The unfinished business. We had two tabled motions. They were tabled until this meeting. Is there any action you wish to take on these?

Dr. Rosenblatt: I wish to recall the tabled motion on the First District PSRO. The motion was seconded and carried.

Chairman Ingram: The motion under discussion is the motion to grant approval to Southwestern Medical Review Organization, Inc. to apply for a planning grant as a conditionally designated PSRO.

Dr. Dukes: The House of Delegates said we ought not to be in PSRO activity and we refused some other people, so I don't see how you can consider one group of people and not consider everyone.

Chairman Ingram: We had a request from the Indiana Physician's Support Agency for a letter of approval as they apply for another year's grant, and it was the action of the Executive Committee not to grant that.

President Wilhelmus: I think Dr. Dukes is a little bit wrong there. They asked for a grant for an organization which is not a part of this Association. This group is a part of Indiana Medical Association with the doctors in southwestern part of Indiana so it's an entirely different situation. Let me read what the Southwest Indiana Medical Review Organization has written me, and I'm not involved with them, so I'm going by this letter entirely. "As you know, the Southwest Indiana Medical Review Organization has submitted a preliminary contract proposal for federal funds to develop a conditionally designated professional standards review organization. This organization proposed a time period of twelve months and a total budget of \$78,000. To the best of my knowledge,

SWIMRO, which is their PSRO in southwest Indiana, is the only organization in Indiana according to Professional Standard Review which has a board made entirely of official representatives from each medical society in the PSRO area. I'm writing to officially ask for a letter of support from ISMA to supplement our proposal and hope you will present our request at the earliest opportunity."

Dr. Harshman: We've gotten in trouble before by endorsing or not endorsing and I'd be very interested to know what the feeling of the county medical societies and the district medical societies are in that area. I certainly wouldn't want to do anything to go against their wishes, and I have no idea what those groups feel about it.

Dr. Rosenblatt: I don't know what the interpretation the Executive Board has made on the directive of the House of Delegates at the last convention. There was nothing said about us not doing anything for PSRO. It said that since it is the law of the land, we must go along with it; however, we will continue to do peer review and we will continue to work for repeal of PSRO. It does not say that the House of Delegates directs us to disapprove.

Dr. Goodman: I am being asked by constituents of my district (some of whom you know have had some very strong feeling) if I can tell them what the present position of the Indiana State Medical Association is in regard to PSRO. I think it was very clearly stated by the last House. We will seek to change the law by amendments until such time as we feel it possible to repeal. In the meantime, to attempt to amend it to a point where we can try to work with it, I believe, is an accurate statement. I would like to move at this time we disapprove this request.

Chairman Ingram: It has been moved that we disapprove the request.

Motion was seconded and the discussion continued.

President Wilhelmus: Mr. Chairman, I know very little about this SWIMRO in southwestern Indiana because I'm not involved with it. I would like to ask the Board's permission to have the secretary of Vanderburgh County Medical Society, Mrs. Carole Rust, who has been involved with SWIMRO, to give her presentation. This isn't the reason she's here. She's here to listen to AMA comments; but since she is here, I'd like for her to comment if the Board will allow it.

Chairman Ingram: All right.

Mrs. Rust: Thank you, Dr. Wilhelmus. Vanderburgh County took the lead in this area after waiting for AMA's action last summer and the House of Delegates last fall. We had done some preliminary organizational work, but very slowly. Our president, Dr. Young, whom some of you may know, contacted each county medical society in our PSRO area and

told them he would like to get together and talk about this after the October House of Delegates' meeting last year. They agreed and they sent representatives. We met twice; and at the end of that time, we had come to an agreement to try to organize and prepare a contract proposal. No one was enthused, but we felt we had to move. And so an organization which had been created was adapted for the purposes of PSRO and agreement was reached that a contract proposal should be prepared. And it was, and it has been submitted. The proposal suggests that the funds come to southwestern Indiana. We had a little assistance from the Indiana Physicians' Support Agency but we are not proposing to be funded through them. As Dr. Wilhelmus said, quoting from Dr. Young's letter, this board is composed of officially named representatives from each county medical society in our area. These are not self-designated people. They are named by the societies which make up ISMA, and it is, I think, somewhat different from some of the other PSROs—in my mind, it is different from the Indiana Physicians' Support Agency.

Dr. Dukes: Tell me the difference again.

Mrs. Rust: Well, each member of this Board has been named by a county medical society. Indiana Physicians' Support Agency has a board; some of them have been invited to represent an area.

Dr. Harshman: Mrs. Rust, when you state that each county has sent a representative to this organization, does that imply their approval of this organization?

Mrs. Rust: It implies their willingness to participate, and at the time they were asked to send a representative to the Board they were told it was for the purpose of organizing to carry out professional standards review. That wasn't done until after the initial two meetings at which we met to find out how people felt and whether to go ahead or forget it. The decision was to go ahead.

Dr. O'Neill: Why do you need a letter of approval?

Mrs. Rust: Part of the request for proposal suggests that you have a letter and the first organization mentioned is from your State Medical Association. Now, we have a letter of support from every other organization or type of organization that they list, including a citizens' health organization, which is a health and retirement fund of United Mine Workers.

Dr. O'Neill: You can still submit your application without the letter?

Mrs. Rust: Oh, we can, but it's weakened. We're in competition with the whole country on this.

Dr. Goodman: I wish to proceed with the action on this. I would move at this time, inasmuch as there is a meeting of the AMA at Atlantic City next week,

which in the conduct of its business will consider some of the resolutions concerning PSRO which might possibly affect our thinking, we again table this matter until our next regular meeting which will be in August.

Motion was seconded, put to a vote and carried.

RESOLUTION ON RELICENSURE OF PHYSICIANS

Chairman Ingram: Next is a motion on a resolution to AMA regarding fiscal matters and relicensure of physicians. Does anyone want to speak to that or bring it back for discussion?

No one spoke to the matter. The chairman went on to the next item of business.

PRESIDENT'S REPORT

President Wilhelmus: I've been traveling over the state as well as the country. I want to thank the hospitality of Richmond, Batesville, and Vincennes coming up this week, and other district societies. I am trying to attend most of them. Some of them have meetings on the same day which makes it impossible to attend both.

I have a letter here from the Indiana Academy of Physicians' Assistants. I'd like to read a paragraph of it to see what this Board wishes to do. "The Indiana Academy of Physicians' Assistants has been actively encouraging the enactment of enabling legislation for the PA in Indiana. We are again planning on pursuing such legislation, and we think we need total and active input from ISMA. In addition, we would appreciate your guidance in other professional matters that come before this Academy. For these and other reasons we feel a strong need for a liaison person from your organization." They're asking us to form a liaison with the physician assistant program.

Dr. Bryan: I would like to speak to that. I don't believe it is so much a request for the program as a request for liaison member to work with all the PAs—not just the Fort Wayne program.

President Wilhelmus: I would move that we appoint a liaison individual with the PAs.

Dr. Goodman: I will second the motion.

Dr. Scamahorn: On behalf of the Medical Board of Registration and Examination, I would urge that the State Medical do this because there has to be some legal status here. We've got to legalize a person who takes the PA program and is working for a doctor. He doesn't have an RN degree; he doesn't have a physical therapy degree; he doesn't have an LPN degree; he doesn't have anything to fall back on; and we've got to give him some legal status.

Dr. Dukes: Why does it have to be legalized?

Dr. Scamahorn: I feel he does, and the Board does. He has to get some legal status. I did not say he had to be licensed.

Dr. Thatcher: I heard discussion on this just this week and those physicians who are using these individuals in the state of Indiana are in jeopardy on malpractice. These people cannot get malpractice insurance; there is no rationale to offer malpractice insurance to them. You are liable for their actions and it is a real grey area and can constitute a difficult situation.

Chairman Ingram: The motion is for a liaison representative. I'll call for the vote on the motion.

Vote was taken on the motion and it carried.

President Wilhelmus: I appoint Frank Bryan. The next item on my President's Report is to advise you that the insurance commissioner for the state of Indiana has resigned. We invited the assistant insurance commissioner, Mr. Clampitt, for discussion on St. Paul's Medical Liability Insurance for the state of Indiana. His office has been 100% against St. Paul's writing claims-made policies in the state of Indiana. There are 864 doctors in the state with St. Paul. A lot of these doctors had their policies renewed this past January, February, March, April, etc. Some will come due in July. The insurance commissioner is in a bind here. He is reluctant to give claims-made policies in the state of Indiana, but he is also reluctant to see 864 doctors out looking for a new insurance carrier. At the present time, St. Paul will not change. Now, I think we have several ways to go—let St. Paul write claims-made policies or to refuse and St. Paul will pull out and we'll have 864 doctors. The insurance commissioner says if they do that, we do have a risk manager who can help these 864 doctors and he can get them occurrence policies for the state of Indiana, but their premiums are going to be higher.

This Board can say no, we will not authorize claims-made policies and you can send your president with his attorney and maybe one or two other doctors to see the president and chairman of the board of St. Paul and ask them to change their minds. If it's done this way, they may give in for awhile. I don't know, it's just a suggestion. Or, we could give St. Paul a moratorium of three months until the doctors in July, August and September can get insurance through risk management and some other claims occurrence policies. I hope this Board will not fall into the trap of okaying St. Paul to write claims-made policies. One other thing, as you know, Dr. Wright and his organization has had an attorney analyze H.B. 1460 and it was his attorney's opinion that any claims-made policy at the present time is not constitutional in 1460. Our attorney, Mr. James Stewart,

takes a different viewpoint to a slight degree. The insurance commissioner takes an entirely different viewpoint. He says that if he okays the claims-made policy, it will be covered by 1460. So this opens up a little problem.

Chairman Ingram: The motion last time was that ISMA is opposed to claims-made insurance. The motion was tabled until July 1, I believe, at our president's request. And so in order to have a legal discussion, I would like to see this called back so we can do it right.

Dr. Schauwecker: I so move.

The motion was seconded and carried. There followed a lengthy discussion of the motion, with Mr. Clampitt answering numerous questions.

Chairman Ingram: We are now immediately voting on the original motion which is the statement of ISMA's opposition to claims-made insurance.

A vote was taken on the motion and it carried.

President Wilhelmus: Mr. Chairman, as I understand now, the insurance commissioner's office will go the governor's office and carry this message. Do you want the delegation representing the ISMA to attempt to make an appointment with the president and chairman of the board of St. Paul Insurance and see if we can get them to utilize 1460, which is supposed to be the leader of the country?

Dr. Schauwecker: I so move.

Dr. Goodman: I will second that motion.

Chairman Ingram: It's been moved by Dr. Schauwecker and seconded by Dr. Goodman that the president be delegated with the others mentioned to pay an official call on St. Paul to see if they can influence them.

A vote was taken on the motion and it carried.

MOTION OF APPRECIATION

President Wilhelmus: Mr. Chairman, I'd like to make one motion. I'd like to move that the Board go on record thanking Mr. Clampitt for coming here on Sunday morning.

The motion was seconded, put to a vote and carried.

Chairman Ingram: President-elect Santare is not here and Dr. Ramsey has had an emergency so he's asked me to make his Journal report for him. It is this—he is losing exactly the right amount at exactly the right time! We'll now have the treasurer's report.

TREASURER'S REPORT

Dr. Thatcher: Upon authority of the Board, we finally consummated the sale of the Johnston funds. We had purchased \$25,000 worth back in 1968. When we sold them, we received only \$29,297, which left a book market loss of \$3,173. However, since we paid \$25,000 for it, and we received \$29,297, we ac-

tually had a gain of \$4,297.25 which, over the seven years, netted us a 2.455 interest rate per year. I think we sold them at the right time. I think this should be turned into the General Fund to cushion some of our losses due to our malpractice insurance activity and then consider what we're going to do for the future and pick up the difference in dues increase next year. I move this report be accepted.

The motion was seconded, voted on and carried.

TRUSTEE REPORTS

Chairman Ingram: We're now to the reports of the trustee districts, remissions of dues and meeting dates.

1st District, Dr. Rosenblatt: No report.

2nd District, Dr. Holtzman: The district meeting will be June 11 at the Vincennes Elks Club.

3rd District, Dr. Goodman: I have a request through the Clark County Medical Society for remission of American Medical Association dues for this year for a physician due to disability to practice medicine.

The motion was seconded, voted on and carried.

4th District, Dr. Jackson: We met June 4. Dr. Alvin Henry from Columbus was elected our Blue Shield member. Dr. Wilhelmus spoke that evening about the malpractice problem, and our meeting next year will be in Decatur County.

5th District, Dr. Schauwecker: The Fifth District held its annual meeting at the Holiday Inn at Terre Haute on May 14. The business meeting was very well attended with Mr. Robert Amick representing the ISMA and Mr. Gary Miller representing Blue Cross. Two past presidents of the ISMA were also present: Dr. Joe Dukes and Dr. Malachi Topping, Terre Haute. There was considerable discussion concerning the recently passed Malpractice Act. It was also noted that several doctors had received notices of a marked increase in their malpractice insurance premiums—apparently chiefly from one company, with no relationship to past or present litigations. It is apparently statewide. Some expressed the view that the ISMA should give considerable study to starting its own insurance company. Others thought that the recently enacted law should be given a chance to work, and perhaps such a major step might not be necessary.

The election of officers was held and the new officers for the Fifth District were as follows: Dr. Robert Oehler, Brazil, was elected president; Dr. Nancy Oehler, Brazil, was elected secretary-treasurer. The meeting next year will be held at Brazil.

Also elected was Dr. Edward Johnson, Terre Haute, to fill the unexpired term of Dr. Fred Dierdorf, Terre Haute, as Blue Cross representative. Dr. Dierdorf is moving to Florida. Also, Dr. Cleon

Schauwecker, Greencastle, was re-elected Trustee of the Fifth District.

After the dinner, Mr. Temple Spencer gave a very thought-provoking talk concerning the good and bad sides of the medical profession, as well as the country as a whole. The talk was very well received.

6th District, Dr. Inlow: Our meeting was held at Richmond on May 15 and Dr. Glen Ward Lee was re-elected as the alternate trustee.

7th District, Dr. Ferrara: There is a letter. It will be referred to the executive session.

7th District, Dr. McCallum: I would like to request remission of dues for three physicians.

Request was seconded, voted on and carried.

8th District, Chairman Ingram: We had our meeting June 4, Portland Country Club. I want at this time to thank Dr. Haley for coming. We had a trustee election and Dr. Jack Walker of Muncie will be the new trustee in the district. Our alternate is still the same—Dr. Alexander of Muncie.

9th District Dr. Sholty: Ours is to be June 12 at the Curtis Creek Country Club, Rensselaer, and Governor Bowen will be our after-dinner speaker.

10th District, Dr. O'Neill: The 10th district meeting will be September 24 at the Valparaiso Country Club.

11th District, Dr. Harshman: I have a dues remission for a physician who died on April 4, and Grant County has approved of the remission.

Chairman Ingram: That was taken up in the Executive Committee. We established a policy on deaths.

Dr. Harshman: What is the policy?

Mr. Waggener: The trustee discusses the matter with the county; the county approves it, and then we follow through.

Chairman Ingram: We don't have to bring it up to the Board on the death. The trustee and the county are the controlling factors.

12th District, Dr. Haley: The 12th District will be at the Ramada Inn in Fort Wayne on September 11. There will be open golf in the afternoon at Pine Valley. I would like to move the remission of dues for a physician. He will be out of the country for several years on a medical-missionary junket and it is my understanding he is without salary for this position.

The motion was seconded.

Dr. Thatcher: Question of order. Dr. Haley, shouldn't there be some request made for reclassification of his membership under those circumstances?

Dr. Haley: I've been through the constitution and I'm not sure where he would fit in except under the service-men's classification and I think I'll have to talk to the administration. He would like to continue as a member, but he can't pay the dues, obviously. Whether

we can send him The Journal or something, I don't know.

Chairman Ingram: We have a motion properly made and seconded to remit his dues. This is a one-year-type thing, so I'll trust you, Dr. Haley, to look into the remaining details.

The motion was then voted on and carried.

Dr. Schauwecker: Would a motion be in order in this particular case to have the State Medical Association continue to send him The Journal free of charge?

Chairman Ingram: I would presume that any motion you want to make, the Chair would have to hear.

Dr. Goodman: I will second that motion.

Dr. McCallum: I think this really needs to be carried further. Marion County has discussed this several times. There's a terrible discrepancy between the AMA qualifications for membership, the state and then the various counties, and I think this—constitutional bylaws or some committee—needs to study this. Whether we have to wait until the next session or state meeting to go about this, I don't know, but there ought to be a disability status or some status which we could extend a person like this.

Chairman Ingram: Those in favor of Dr. Schauwecker's motion to send this gentleman The Journal signify by saying "aye." Opposed, same sign.

The motion carried.

13th District, Dr. Gattman: Our meeting will be September 10 at South Bend Country Club.

MEDICAL EXAMINERS SYSTEM DISCUSSION

Chairman Ingram: Next item is new business. This is a question from me because we discussed this last time under the legislative commission report. Should the Board submit a resolution to ISMA House of Delegates urging the legislature to establish a medical examiner system? There was a bill in the legislature that didn't make it concerning this item so do you want to do something through our House to stimulate this?

The motion was seconded.

Chairman Ingram: It's been moved and seconded that the Board introduce a resolution to the ISMA House of Delegates urging the legislature to establish the medical examiners system. Is there discussion?

Brief discussion followed. The motion was put to a vote and carried.

Chairman Ingram: Mr. Waggener, will you word that and have it ready for us?

COMMITTEE ON SPORTS AND MEDICINE REPORT

Chairman Ingram: This is a rather lengthy presentation and having read it briefly I don't understand it very well. Dr. Bomba was to come today and present this so that we could all understand it with clarity. Dr. Bomba has had

two emergencies and can't come so we'll put it on the agenda at a later date.

NEW BUSINESS

President Wilhelmus: Mr. Chairman, under new business I would like to discuss our annual convention. The Sports Committee and the Convention Arrangements Commission have been working very hard. I think we have a dynamic convention coming in October. If you've not made your reservations for the French Lick Hotel, I urge you to do so because they just have so many rooms. We've broken this down from a five-day to a three-day convention and we have entertainment practically every night for you. We have an ESP man for one night. I have a contract coming back this next week, I hope, from a man all the women would love to see and hear talk. Tuesday night, we have the number one basketball coach in the country—the number one football coach—the number one doctor with the Olympic Team—go right down the list; there's a lot of dynamic people coming. I do urge everyone to make a room reservation.

Chairman Ingram: The schedule is from the 20-22. I assume the Board will meet on the 19th.

President Wilhelmus: I'll give a breakdown real quickly, Mr. Chairman. The Executive Committee will meet at 10 a.m. on Sunday and the Board of Trustees will meet at 2 p.m. That evening there will be a Board dinner, Sunday, October 19. At 9 a.m. the House of Delegates meets on Monday, the 20th. At 1 p.m. or 2 p.m. the reference committees start. That evening, Dave Hoy, who's been on radio, TV throughout the country (quite an ESP man) will give a program. The next day will be devoted to the sports program entirely. That evening, a cocktail party. A pharmaceutical company in my hometown has offered to sponsor the cocktail party—so come, free drinks. That evening we will have a TV personality. Wednesday morning at 9 a.m. will be the last House of Delegates meeting and it'll be over by that evening. The specialty groups are going to meet on Monday and Wednesday and I think a couple of them will be meeting Tuesday afternoon. I made a trip to French Lick last Wednesday and they have remodeled part of it and it really looks good. They've got new bowling alleys, new sauna baths; they've got new sulfer baths, new billiard tables, and another swimming pool outside. I was impressed with it. I think it's going to be a real good convention and I think a lot of people will be there. I would suggest that the Board get room reservations in early so they won't be left out.

ISMA INSURANCE PROGRAMS

Chairman Ingram: All right, is there further new business at this time?

Dr. McCallum: Several of our Marion

County members have brought to our attention the inconsistency of the ISMA-sponsored insurance programs. We approved of major medical with Blue Cross. We also have a CNA major medical and many of our members have both programs. I think this should be referred to the appropriate committee, whether it's the insurance committee or the executive committee, to study the problem.

I so move. Motion was seconded.

Chairman Ingram: It's been moved and seconded that we refer this conflict in the major medical coverage, which we have available, to the Commission on Medical Economics and Insurance.

Mr. Waggener: I would remind you that the Commission on Medical Economics and Insurance is responsible for the Continental program, but this Board is responsible for the Blue Cross/Blue Shield plan.

Chairman Ingram: I understand that. I see no reason they couldn't study the problem for us and make recommendations. Any objections to that?

There were no objections. The vote was taken on the motion and it carried.

NOMINATION TO AMA COUNCIL

Chairman Ingram: Dr. Pat Corcoran has been nominated by the Board of Trustees of AMA to become a member on the Council of Medical Education. Is that correct?

Dr. Corcoran: To run for it.

Chairman Ingram: To run for it. It was the feeling that some expression should be given by this Board concerning that.

Dr. Thatcher: I would move that this Board not only express its desire that he run but also circularize other medical associations in the country with our endorsement of his having been nominated.

Motion was seconded. Dr. Corcoran commented to the Board on his candidacy. The vote was then taken on the motion and it carried.

AUGUST MEETING OF BOARD

Chairman Ingram: We did approve the idea of returning to the Inn of the Fourwinds for an August meeting. You recall that we did limit that to \$50 per man plus travel so that expenses would not be out of line with what they are here. We have two sets of dates available. Those dates are Aug. 8, 9, and 10; Aug. 22, 23, and 24. The executive Committee last night made the recommendation that the Board approve the 8, 9, and 10th of August—the reason being that the other is right at the start of school and might be a difficult problem.

Dr. Goodman: I move that we accept the dates August 8, 9, and 10.

The motion was seconded, put to a vote and carried.

Chairman Ingram: Dr. Kerr has once again agreed to make arrangements. He

did a magnificent job last year and everyone that was there had a grand time, I think.

Dr. Sholty: Will the local office make our reservations?

Dr. Kerr: I talked to the management people down there and asked them to hold 50 rooms. They said they would hold these until the last weekend in July. Instead of word going out and reservations being made through headquarters, I am going to give them a list of the people who would be involved with this and they will directly send to you a reservation form. You send it directly back to them and eliminate some of the mechanics in headquarters here. It also helps them to keep their records straight.

FORUM FOR MEDICAL AFFAIRS

President Wilhelmus: I have a question, which we discussed last night, which I was supposed to bring before the Board. That was the fact that Mr. Waggener, who's been secretary for the Forum at the AMA convention, is no longer nominated, and I don't know if we should bring this now or to the AMA.

Chairman Ingram: I think it falls in this category. This is the only thing we have left except executive session and the report from the Board committees. Since I'm going to turn this over to you in a minute, you do it as you see fit. You're the chairman of the delegation concerning the reports.

Later, during the reports of the AMA delegation, it was emphasized that an error had inadvertently occurred in eliminating Mr. Waggener from the slate of officers for the Forum and that steps had been already taken to correct the oversight.

LETTER FROM DR. SCHUSTER

Chairman Ingram: I do have a letter, however, that I'm going to call to your attention to see if you want to refer it to the AMA delegation. This is from Dwight Schuster, dated May 19, 1975, to Mr. James Waggener. "Dear Jim, I'm enclosing some material which I hope you will bring to the attention of the proper individuals. It has to do with AMA resolutions. On behalf of the Nervous and Mental Section of ISMA and the Indiana Psychiatric Society, I am authorized to report unanimous support of the Illinois Medical Society resolutions, particularly 75-16, 75-17, 75-20, 75-52. We agree that 75-16 could be worded better but we believe and have attempted to get that point over to our state legislators that community health centers are not the total answer to all mental illness and that government funding should not be solely or majorily directed to community mental health centers. If there are questions, if I can help in carrying forward these opinions, please let me know. Sincerely yours, Dwight W. Schuster, M.D." Do you wish to do anything with this?

Dr. Harshman: These resolutions are in the Handbook and perhaps the Board can make disposition of them as each delegate or alternate delegate discusses the appropriate reference committee. They are all in the Handbook with the exception of the one he refers to as 75-52. That resolution was never introduced so I don't think there's any action that can be taken because these resolutions cannot be submitted at this late date. I think that we can dispose of these as we go through the reference committee reports.

Chairman Ingram: All right. Then could I ask each of the AMA delegation as these resolutions fall in the purview of your discussion, will you mention them?

Dr. Harshman: They're all in Reference Committee B.

REPORTS OF AMA DELEGATES

Chairman Ingram turned the meeting over to President Wilhelmus, who presided on the reports of the AMA delegation concerning the forthcoming AMA meeting in Atlantic City.

During the discussion on PSRO, Dr. Eli Goodman made the following remarks:

Dr. Goodman: Mr. Chairman, I would like to make some comment and some suggestions in regard to the 19 resolutions dealing with PSRO and if you'll bear with me a minute or two, I would like to go back two or three years to the time when I think everyone in the nation agreed that this was a bad law, and we all scurried and talked with our legislative people and we were told that as a practical matter it was not possible that PSRO could be repealed at that time. So that in the opinion of many sage people, the best avenue open to us was to continue to try to amend this law and not at the moment fight for repeal because it would be mechanically impossible.

Subsequent to that time, I, as one individual, have chosen to try to maintain legislative contact on this thing, and I get this kind of feedback from the members of the Congress with whom I deal, "Well, you guys, you used to tell us about all these bad things about this, but you know what, your national organization came out in favor of it." So this is a very, I think, undesirable position from that viewpoint.

Then going back through '74 and '75 and the position of the vast number of physicians on the American medical scene, is that this is a bad law. In '73, I think it was '73, we nationally stated that we thought this was a bad law, then we came around to following what the politicians told us. We all said privately, yes, this is a bad law, but publicly we have to take the posture that we'll try to amend it and live with it. And then we met in Chicago last summer. I attended the reference committee hearing on PSRO

which I think lasted 5-6 hours and there were some 70-75 speakers and there were varying viewpoints. It was a very interesting and, I think, highly democratic session and then we went to the House of Delegates and at noon someone was at the microphone and at 12:52 the gong sounded and the audience, in my opinion, was stunned. I think that while this may have been according to Sturgis, or whatever, it had a very highly undesirable effect on the body politic of American medicine. And I think there are two or three things we owe to American medicine and we certainly owe to Indiana medicine because we well know the position of Indiana medicine is that we are opposed to PSRO. Having gone to several of these meetings with you, I'd like to make some suggestions and possibly in the form of a resolution from this Board to our delegation.

Number one, I would like for us to make sure that these 19 resolutions are not the last piece of business on the last day of the meeting. Number two, I think we should be certain that our delegation will continue to state our opposition to this legislation, both in the reference committee and on the floor of the House. I would hope that our delegation at this time, when this thing comes to a vote, would ask that for once there be a roll call vote in the House on this very crucial issue. Now, the reason I ask for the last thing is that after the last meeting and my discussion around on the floor, the thing I heard, and back home the thing I heard, was, Well, my God, what happened? You go down the street and talk to 30 physicians and 29½ of them opposed the PSRO. I think the fellows back home who send you people to Chicago or wherever are entitled to know how you voted so I would in the form of a resolution just so the thing would be crystal clear would ask that you restate our opposition both in reference committee and on the floor—that you try to see to it that it is dealt with before the last day of the meeting and that there be a roll call vote. I will so move.

President Wilhelmus: There's been a motion.

Motion was put to a vote and carried. Later in the meeting discussion continued on Dr. Goodman's motion.

Dr. Harshman: Could you clarify your motion? Are you asking for a roll call vote on all 250 members of the House of Delegates or the Indiana roll call vote or . . .

Dr. Goodman: Dr. Harshman, there were 19 resolutions concerning PSRO that were going to go to the reference committee. Now you and I both know that almost for certainty the reference committee will come up with a substitute resolution and put them together. And if the reference committee is doing its job at all, this substitute motion will once

again create a quorum in which the House can express its viewpoint regarding PSRO. And at that point, in contradistinction to the meeting in Chicago, there had to be men get up and vote in favor of who had been saying they were against it. There just had to be. If you recall, we had our own political pros out doing head counts and Guy Owsley came to me the night before and said that PSRO thing would go down, 135 to something. There had to be people who were stating one position and voted another position. This is the thing I have been hearing about the AMA ever since that meeting—that the fellows felt they didn't know what their delegates up there did. I am proposing that there be a roll call vote at a point when the House is expressing itself regarding PSRO. That, I anticipate, will be a substitute resolution.

Dr. Harshman: I might add that at the Chicago meeting a motion for a roll call vote was made.

Dr. Goodman: Let's start earlier and plug it more and tell why.

Dr. Harshman: It was soundly defeated.

Dr. Goodman: The people didn't want to take the time, simply. I think the people who represent us up there ought to know that the boys up in the boondocks did not appreciate that. It takes time for a roll call vote. Yes. But this was a very crucial issue and I think people should have been put in a position of a roll call vote.

Dr. Harshman: Well, I can tell you that first of all the Indiana Delegation supported the motion for a roll call vote. We opposed termination of debate.

Dr. Goodman: Dr. Harshman, this delegation did everything right and I bless you for it—also in my annual report. Nevertheless, that House failed to allow the boys in the boondocks to know who voted what way and I think it was a serious omission for that issue.

Dr. Steen: I appreciate your position and I know you feel very strongly about this but you know the boys in our boondocks in Indiana have only got hooks on five people. We don't have hooks on the boys from California and from other states. I'll grant you they are all part of the body politic of the American Medical Association.

Chairman Ingram: Right now I am going to interrupt this a little bit. We have a motion that has been made, properly seconded, and passed concerning this. Unless there is a motion to reconsider, let's not go on.

I-MEDIC

Chairman Ingram: We have one more item I would like for you to approach right now and that concerns I-MEDIC and I would like to call on Dr. Petrich to inform you what we are talking about.

Dr. Petrich: Last night the Execu-

tive Committee had a rather prolonged discussion about some very attractive programs for I-MEDIC to pursue. This will take a great deal of study and work before anything definitive can be proposed to you but will present it to you for your information and that of the chairman. We are at sort of an impasse at the moment though. ROCOM would like to negotiate with Winona. They have not offered a proposal to Winona Hospital for their system because they wanted to continue to deal through us as they had proposed originally—that we would be the supervisory intermediary for the whole system in any hospital in the state in which it was instituted. And I think that idea is still a good one. In order for us to stay in that position at the moment, we would have to enter into a contract with ROCOM. The advisability of doing that is not too great as far as I am concerned right now. I would like for us to, with your endorsement, to tell ROCOM tomorrow to enter into a proposal with the staff and the administration of Winona Hospital on a one-to-one basis with us as a non-contractual observer and interested third party to observe the results of the program in operation in the pilot.

Chairman Ingram: We have a motion to that effect from Joe Ferrara.

Motion was seconded.

Dr. Goodman: Mr. Chairman, I think we need a little discussion. We formed I-MEDIC; we had a 90-day period allotted to test it in one hospital; we increased the 90 days to 180 days; we talked about I-MEDIC being a viable alternative to PSRO; we talked about I-MEDIC possibly being a source of earned income for our Association. I am a little bit lost.

Dr. Petrich: I don't know why you should be. We are still in the same ball game as far as finding out all those things. The pilot would not have brought us any money, number one. The contract, I think, at this time would bind us to the utilization of that particular system and since the system has been put into a specimen operation on one occasion in the recent past of the hospital, some of the doctors there, I understand, have some reservations about it—about the conversion of that system to their own standards and all the things we talked about.

And I think right now we ought to let the company do it if the hospital staff and the administration are willing to do it (there is some reticence on their part) and I don't want us to get into a binding situation that would hold us from now on. I think we can accomplish all of what we want to. Besides this, the presentation last night offers us some additional opportunities to do all the things you just brought up. As I say, there is not enough information yet about that particular thing to pursue it.

Dr. Goodman: We won't permanently lose that hospital?

Dr. Petrich: No, and we won't lose contact with ROCOM. We will just not have a formal contract for this pilot program.

Chairman Ingram: As I understand, all the information is for keeping our options open right at the moment.

The motion carried.

**PUBLIC INFORMATION
COMMISSION REPORT**

Chairman Ingram: I will call on Dr. Crane.

Dr. Crane: Basically, Dr. Goodman asked me about the Speakers' Bureau and our funding, etc. I told him we were not spending the whole \$40,000—that we were talking about the possibility of these funds, or a portion of them, being used in this same general direction consistent with one of our speakers, Mr. Tim Spencer. Tim was a radio and TV commentator in Evansville, and Mr. Courtney Smith is a part-owner of a radio station and is also a radio broadcaster. Tim put together a radio tape to be used during this bicentennial year. This tape has a 90-second space for a commercial for the State Medical Association that could be used just as a promotional kind of thing in terms of the Bicentennial year. We felt we could get a lot of good publicity and mileage as a medical association.

The Board then heard the tape and asked questions concerning the program.

Chairman Ingram: Are there other questions you want answered while these men are here concerning costs, etc.?

Dr. Crane: The total cost for the programs, including having them run on the 20 stations throughout the state, 13 weeks over a one-year period beginning in July of 1975 to July 1976 (which would be the period of greatest impact in terms of the Bicentennial) would actually total about \$17,000.

Dr. Sholty: Does this entail money out of the budget?

Chairman Ingram: He's talking about the Speakers' Bureau money.

Dr. Sholty: Does he need any action from the Board this afternoon?

Chairman Ingram: If this is to go on, yes, the Board will have to approve it because it is an extension of the Speakers' Bureau. The House established a Speakers' Bureau and this would be an extension of that.

Dr. McCallum: I'd like to point out that the reference committee at the State meeting made several suggestions for this commission—television tapes, radio station tapes—the idea was completely opposite to what he's talking about, which is pure advertising. I know Wally Bruner approached Marion County Medical Society, not for sponsorship, but for approval of his meditates which is at no cost to us. I think this sort of thing

would do us much more good in the long run at no expense.

Chairman Ingram: We don't have a motion now, so I'm going to ask you to stop the discussion until we have a motion, if you wish to make one.

Dr. Inlow: I move that we support Dr. Crane's proposal.

Motion was seconded.

Dr. Goodman: I think it might be germane if I were allowed to make the report of the Board Committee on Economic and Fiscal Matters before you take action.

The motion was made, seconded and passed that the motion to support Dr. Crane's proposal be tabled until after the report of the committee.

**REPORT OF COMMITTEE ON
ECONOMIC AND FISCAL MATTERS**

Dr. Goodman: Mr. Chairman, your Board Committee on Economic and Fiscal Matters met today and took up five separate and distinct matters.

We first met with Dr. Crane, who has been allotted, I think, by mandate of our House, \$10 a year for two years for a public speaking program. Our records show he has a balance now of some forty-thousand dollars after paying a commission to the organization that is selecting the speakers for us. Dr. Crane, at our meeting, suggested that perhaps his group would not need as much money as we have given them in the past. There was some suggestion that perhaps some of the money ought to be reallocated to people working in public information, separate and distinct from Dr. Crane.

We then discussed with the Student Loan Committee the matter of the unused, or unsolicited money in our student loan fund. Dr. Scamahorn met with us, as well as a young gentleman who was representing Dean Beering of the I.U. Medical School, and they proposed we convert our student loan fund into a miniature AMA-ERF fund. I won't take your time to go through the differentials with you, but in the light of the increasing economic pressures on students that are taking place now and the increasing unavailability of loan monies, perhaps we should keep this money for that purpose and make the conversion. The Economic Committee authorized Dr. Scamahorn and his people to meet with the bank representatives and see what it would take to make the conversions. If this is possible, we will report this to you later or at your pleasure.

We next discussed a rather lengthy document which was presented to us about 30 minutes before our meeting that had to deal with pension reform and in order to meet with new changes on the laws regarding pensions, we're going to ask our staff to prepare a plan which encompasses the changes and indicate to us how much additional budget for that month will be needed.

We next discussed the matters of monies that have been received through the sale of Johnston Fund shares in the amount of \$29,000 and it was our feeling that this money would probably serve us best by reverting into the General Fund, primarily because of the fact that we are running about a \$70,000 deficit in financing the money spent for professional liability.

We also talked about increasing the dues. We decided to ask the staff to provide us a proposed budget for the August meeting so we can make a recommendation to the House in October. I think you can look for a dues increase.

Chairman Ingram: We'll expect a concrete recommendation in August at our meeting because that must be adequately prepared to go to the House. We've had a little difficulty with that in the past and we'd like not to have it that way this time. We have just tabled a motion with a specified time that it come back following this report so I would hear a motion to bring that discussion back.

It was so moved and seconded and carried. Discussion on the motion followed.

Dr. Schauwecker: Dr. McCallum said there are some tapes available on medical subjects much less than this. Would it be possible to hear that in our August meeting? We could hear a tape or two and compare before we do something? I move we defer this until August for a decision and hear some of these tapes at our August meeting and make our decision then.

The motion died for lack of a second and discussion continued.

Dr. Goodman: I do not think it would be out of order for me to again move that we lay this on the table until the August meeting with the suggestion that we review samples of both programs.

Motion was seconded, put to a vote and carried.

MEETING IN BROWN COUNTY

Dr. Jackson: I neglected to mention during my report on our district meeting that Dr. Bob Seibel from Brown County, Nashville, has called a meeting at the Brown County Inn regarding the HSA designation for southern Indiana. He's inviting everyone and he especially wants each county society of southern Indiana to send a representative to this meeting on June 17.

AMA DELEGATES' EXPENSES

Chairman Ingram: At the meeting we are going to have at the Inn of the Fourwinds, we do not usually ask the delegation to attend. It is the feeling of the Chair that these men have worked very hard and should be invited to come. I would personally like for your permission to invite the AMA delegates and alternates to come to that meeting. Now the only thing I must have is your advice about the expenses incurred.

President Wilhelmus: I move that their travel expenses be paid.

Chairman Ingram: It has been moved and seconded to pay travel expenses and they pay their own room.

Motion carried.

MOTION OF THANKS

Dr. Haley: I move that this Board thank Dr. Scamahorn for doing a very good job with a tough assignment on Reference Committee F of the AMA House.

Motion was seconded, put to a vote and carried.

ADJOURNMENT

The Board meeting was then adjourned at 4 p.m. with an executive session following.

New Members

The Journal welcomes the following new members of the Indiana State Medical Association:

Bartholomew-Brown County

Ronald G. Bennett, M.D., 4330 Rockyford Road, Columbus 47201 (ORS)

Dearborn-Ohio County

John S. Longcamp, M.D., 370 Bielby Road, Lawrenceburg 47025 (PD)

Delaware-Blackford County

Todd Jerome Hammer, M.D., 1804 Belmont Drive, Muncie 47304 (FP)

Elkhart County

Robert K. Ellis, M.D., 2200 California Road, Elkhart 46514 (P)

Satya P. Kaushal, M.D., 1332 West Indiana Ave., Elkhart 46514 (ORS)

Henry County

Caridad E. O'Connor, M.D., New Castle State Hospital, New Castle 47362 (N)

Kosciusko County

Il S. Kwak, M.D., 1910 Hobson Road #203E, Fort Wayne 46805 (AN)

Lake County

Ivan L. Chermel, M.D., 7905 Calumet Ave., Munster 46321 (DR)

Josefina Phithayanukarn, M.D., 4321 Fir St., East Chicago 46312 (PTH)

Manuel Z. Rosario, M.D., 354 Knox St., Gary 46403 (PTH)

Marshall County

James Daniel Kubley, M.D., 304 North Walnut St., Plymouth 46503 (FP)

Newton County

Romulo S. Jardenil, M.D., 603 East Lincoln St., Kentland 47951 (GS)

Owen-Monroe County

Alan B. Somers, M.D., 619 West 1st St., Bloomington 47401 (N)

Tippecanoe County

Norman R. Hertzner, M.D., 2600 Greenbush St., Lafayette 47904 (GS)

Julius W. Klaus, M.D., Purdue University Student Health Center, West Lafayette 47906 (P)

David R. Potts, M.D., 2600 Greenbush St., Lafayette 47904 (OBG)

Robert T. Williamson, M.D., 2600 Greenbush St., Lafayette 47904 (OPH)

Vigo County

Boris S. Imperial, M.D., 40 Allendale, Terre Haute 47802 (P)

Wayne-Union County

William W. Bronson, M.D., 3625 East Main St., Richmond 47374 (ABS)

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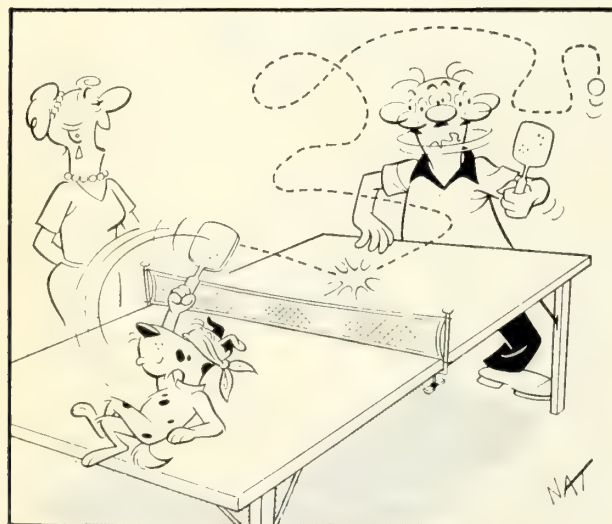
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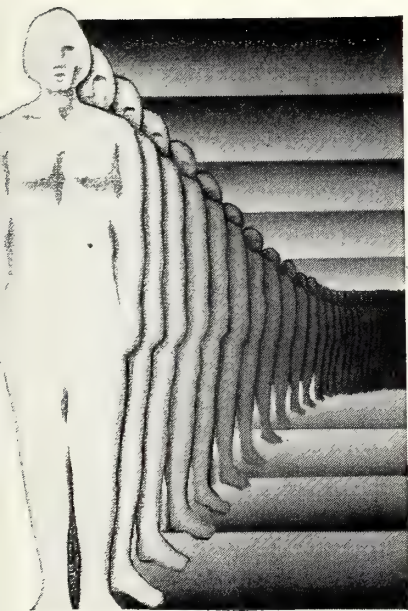
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous

occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 to 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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Important Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media for patients already taking sulfonamides. Increasing frequency of resistant organisms currently is a limitation of the usefulness of antibacterial agents including the sulfonamides. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 12 to 15 mg/100 ml is considered optimal for serious infections; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period. Contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with gastrointestinal disturbances, because of phenazopyridine HCl component.

Warnings: Safe use in pregnancy has not been established. Teratogenicity potential has not been thoroughly investigated. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis. *C.N.S. reactions:* Headache, periph-

eral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, polyarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Usual adult dosage for acute, painful phase of urinary tract infections is 4 to 6 tablets initially, then 2 tablets four times daily for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment of the infection with Gantrisin (sulfisoxazole) may be considered.

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• Predominant psychoneurotic anxiety

• Associated depressive symptoms

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neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

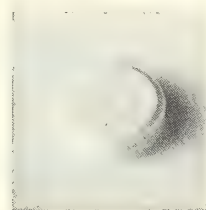
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According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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Elgan L. Miller, 1919 State St. #22, New Albany 47150 (OB-GYN)

Stephen W. Nale, 1000 Spring St., New Albany 47150

Howard County

Rogelio O. Tapino, 401 East Reynolds, Kokomo 46901 (IM)

Lake County

Claudio M. Cabe, 431 Fisher Pl., Apt. D, Munster 46321 (AN)
Felix Millan, 3628 Main St., East Chicago 46312 (PM)

Marion County

Charles M. Action, Wishard Memorial Hospital, 960 Locke St., Indianapolis 46202 (D)

Solomon Batnitzky, 1100 West Michigan St., Indianapolis 46202 (R)

Robert E. Cleary, 1100 West Michigan St., Indianapolis 46202 (GYN)

Robert E. Clutter, 6505 East 82nd St., Indianapolis 46250 (FP)

Samuel K. Cramer, 1303 North Arlington #7, Indianapolis 46219 (IM)

Robert E. Dicks, 8242 South Madison Ave., Indianapolis 46227 (FP)

John S. Freeborn, Methodist Hospital, Indianapolis 46202 (OB-GYN)

Charles W. Hamm, 1100 West Michigan St., Indianapolis 46202 (PD)

Terry Lynn Henderson, 8330 Naab Road #214, Indianapolis 46260 (FP)

J. Stanley Hillis, Veterans Hospital, Indianapolis 46202 (CD)

Paul D. Isenberg, 5626 East 16th St., Indianapolis 46218 (A)

Douglas F. Johnstone, 2020 East 86th St., Indianapolis 46260 (IM)

Jeffrey J. Kellams, 8210 S. Madison Ave., Indianapolis 46227

Phillip F. Merk, Riley Hospital, Indianapolis 46202 (PED)

Dennis W. Miller, 1100 West Michigan St., Indianapolis 46202 (AN)

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Justin Leo Wass, Wishard Hospital, 960 Locke St., Indianapolis 46202 (R)

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EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 3935 N. Meridian St., Indianapolis 46208. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

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Putting out the fires of arthritic pain

Rheumatoid arthritis can sometimes spread like wildfire, with joint after joint going up inflamed. The usual onset is manifested by spotty joint involvement but an acute onset of symmetrical polyarthritis may be noted.^{1,2}

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Each capsule contains:

100 mg. phenylbutazone USP

100 mg. dried aluminum hydroxide gel USP

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If it doesn't work in a week, forget it.



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Ragan, C.: The Clinical Picture of Rheumatoid
Arthritis. In Arthritis, ed. 8, edited by J. L.
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Lea & Febiger 1972, chap 21, p 335

Geigy

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of fever, sore throat, oral lesions (symptoms of blood dyscrasia), dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.

Contraindications: Children 14 years or less, senile patients, history or symptoms of GI inflammation or ulceration including severe, recurrent or persistent dyspepsia, history or presence of drug allergy, blood dyscrasias, renal, hepatic or cardiac dysfunction, hypertension, thyroid disease, systemic edema, stomatitis and salivary gland enlargement due to the drug, polymyalgia rheumatica and temporal arteritis patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpre-

dictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and GI tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions, complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug, its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult GI bleeding with anemia, gastritis, epigastric pain, hematemesis, dys-

pepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult GI bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy, CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia, ulcerative stomatitis, salivary gland enlargement.

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For complete details, including dosage, please see full prescribing information.

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This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

MEMBERS OF THE HOUSE Ways and Means Committee's subcommittee on health have heard testimony from foreign physicians extremely critical of the federalized national health insurance (NHI) system in their native lands and from seven U.S. physicians who urge lawmakers not to allow this country to stumble down the same path.

All witnesses were selected by subcommittee Republican minority members to counterpoise arguments made by liberal witnesses produced during the summer by Democrat colleagues.

The major theme of the American physicians was that Federal interference should be kept to a minimum. Five of the seven physicians suggested that some form of catastrophic insurance might be beneficial.

Clinton S. McGill, M.D., Portland, Ore., told the subcommittee that "freedom within the widest possible latitudes in the practice of medical care is an ingredient absolutely essential to the success of any NHI program."

John Hamilton, M.D., Rochester, N.Y., urged elimination of administrative red tape and proposed a catastrophic plan based on patients' ability to pay.

Marvin N. Lymberis, M.D., Charlotte, N.C., also spoke favorably of catastrophic coverage, warning that an omnibus bill might bankrupt the government and leave the present health system in a shambles.

John Burkhardt, M.D., Knoxville, Tenn., said NHI must be carefully planned, cannot be all-encompassing, and must not interfere with the doctor-patient relationship.

David Masland, M.D., Carlisle, Pa., warned of a possible paper-work explosion if NHI is enacted, urged use of private carriers rather than a Federal bureaucracy, and noted that social factors have the biggest impact on the health of the nation.

Brooker Masters, M.D., Freemont, Mich., said the nation does not have the resources at present for NHI. Rationing of services would be required, resulting in "medical care dictated by edicts in the Federal Registry" which would lead to "chaos."

Donald Quinlan, M.D., Northfield, Ill., read a strongly-worded statement opposing any new Federal programs as "compulsory politicized medicine." He ac-

cused the Administration and Congress of the "great rip-off" of deficit financing.

The domestic panel was questioned by subcommittee chairman Dan Rostenkowski (D-Ill.) and Reps. John Duncan (R-Tenn.), James Martin (R-N.C.), and Philip Crane (R-Ill.). They praised the panel members for their testimony.

Asked by Rep. Charles Vanik (D-Ohio) to give a show of hands on how many would support a catastrophic plan, six of the witnesses raised their hands, but none did when he asked for their sentiments on catastrophic health insurance operated by Social Security. Vanik contended that the public is pushing Congress on NHI, asserting that the lawmakers are not the innovators.

The foreign panel consisted of two British physicians, a British medical writer, a former Swedish physician, and a Canadian physician—Max Gammon, M.D., London; Reginald S. Murley, M.D., London; Anthony Lejeune, Middlesex, England, medical writer; Sigmund J. Lofstead, M.D., Chicago; and Bette Stephenson, M.D., Toronto.

As a group they urged Congress not to permit governmental control of medicine in this country.

The British witnesses painted a black picture of the situation in England. Dr. Murley said almost all physicians in England are totally opposed to the policies of the government and predicted a "massive confrontation" soon.

Dr. Lofstead, who had practiced in Sweden, said health care has become regimented and politicized in that country. Most people in the U.S. he said, have financial access to the best and most sophisticated health care in the world.

Dr. Stephenson was less critical of the Canadian program, but said any NHI program should involve as little distortion of the present U.S. system as possible. She said fee-for-service is the most efficient and fairest method of payment.

Dr. Gammon said it is imperative that the U.S. resist the socialization of medicine "for the good of the rest of the free world." He said that "if you believe that the state is better able to control the affairs of individuals

Continued on page 948

THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

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5—Cleon M. Schauwecker, Greencastle	Oct. 1978
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7—John O. Butler, Indianapolis	Oct. 1977
7—John G. Pantzer, Indianapolis	Oct. 1978
8—Jack M. Walker, Muncie	Oct. 1978
9—William M. Sholly, Lafayette	Oct. 1976
10—Martin O'Neill, Valparaiso	Oct. 1977
11—James A. Harshman, Kokomo	Oct. 1978
12—Alvin J. Haley, Fort Wayne	Oct. 1976
13—G. Beach Gattman, Elkhart	Oct. 1977

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District	Term Expires
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2—Edgar R. Cantwell, Vincennes	1977
3—Thomas Neathamer, Jeffersonville	1977
4—William Blaisdell, Seymour	1976
5—William G. Bannon, Terre Haute	1976
6—Glen Ward Lee, Richmond	1978
7—Paul F. Muller, Indianapolis	1978
7—Donald McCallum, Indianapolis	1977
8—Jack L. Alexander, Muncie	1976
9—Max N. Hoffman, Covington	1977
10—Leonard W. Neal, Munster	1978
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12—Franklin A. Bryan, Fort Wayne	1977
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Alternates: Thomas C. Tyrrell, Hammond; Peter R. Petrich, Attica.

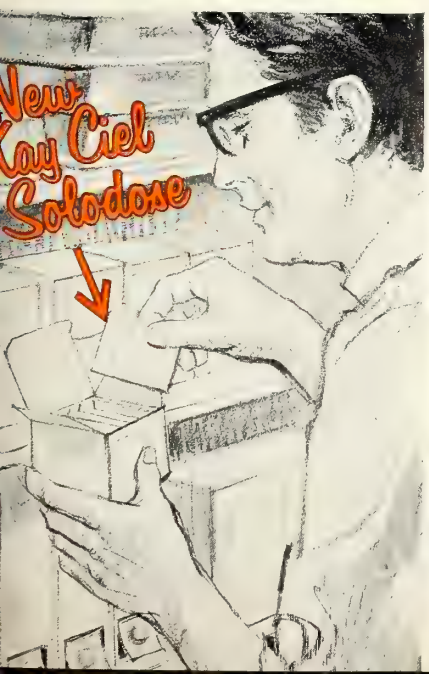
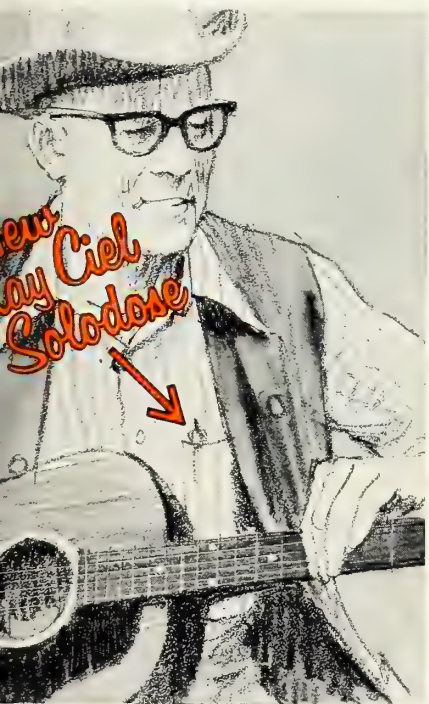
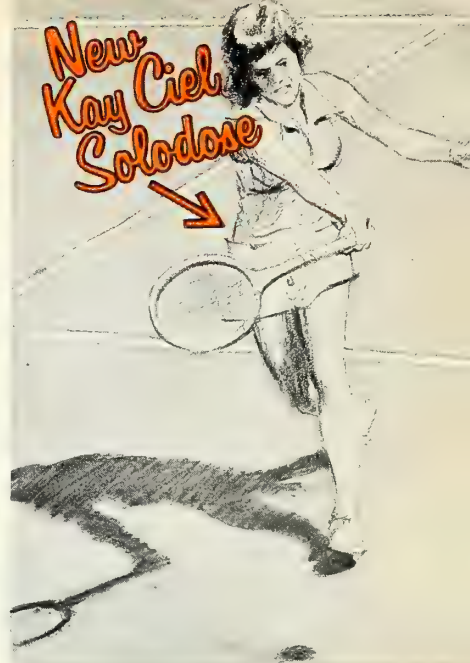
Terms expire December 31, 1976:

Delegates: James A. Harshman, Kokomo; John O. Butler, Indianapolis; Malcolm O. Scamahorn, Pittsboro.

Alternates: George Lukemeyer, Indianapolis; Ross L. Egger, Daleville; Everett Bickers, Floyds Knobs.

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2.	Hamlin B. Lindsay, Washington	J. S. Brown, Carlisle	Washington
3.	Claude J. Meyer, Jeffersonville	Charles X. McCalla, Paoli	Apr. 21-22, Clarksville
4.	Robert P. Acher, Greensburg	Lanny Copeland, Osgood	Greensburg
5.	Robert C. Oehler, Brazil	Nancy L. Oehler, Brazil	Brazil
6.	Wm. F. Kerrigan, Connorsville	Clarence G. Clarkson, Richmond	
7.	John M. Records, Franklin	M. O. Scamahorn, Pittsboro	June 9, 1976, Franklin
8.	Joseph Gahimer, Anderson	James Moneyhun, Anderson	
9.	John A. Knotte, Lafayette	David L. Evans, Lafayette	June 3, Lafayette
10.	Joseph M. Siekierski, Griffith	James R. Brown, Valparaiso	
11.	Richard G. Blair, Huntington	Fred Poehler, La Fontaine	Sept. 15, Huntington
12.	J. Robert Edwards, Auburn	Thomas A. Felger, Fort Wayne	Sept. 9, Fort Wayne
13.	John O. Hildebrand, Jr., South Bend	David L. Spalding, Mishawaka	Sept. 8, 1976



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From the President's Desk

At the recent session of the House of Delegates of the ISMA, Tel-Med was considered for the second year. In 1974 the continued funding of this program was referred back to the Board of Trustees for alternate sources of money. This excellent program was rescued by timely grants from Mutual Medical Insurance of Indiana and RMP. This year the House of Delegates has urged the ISMA to request voluntary contributions for Tel-Med and that is the purpose of this message.



What is Tel-Med? Tel-Med is a telephone health library. It was developed by the San Bernardino County Medical Society and is franchised only to state or county medical societies. It is a collection of tape-recorded health messages which have been carefully selected (1) to help the public remain healthy; (2) to help them recognize early signs of illness; (3) to help them adjust to a serious illness. The tapes are three to five minutes long and can be heard in the privacy of an individual's home. There is no charge for the service.

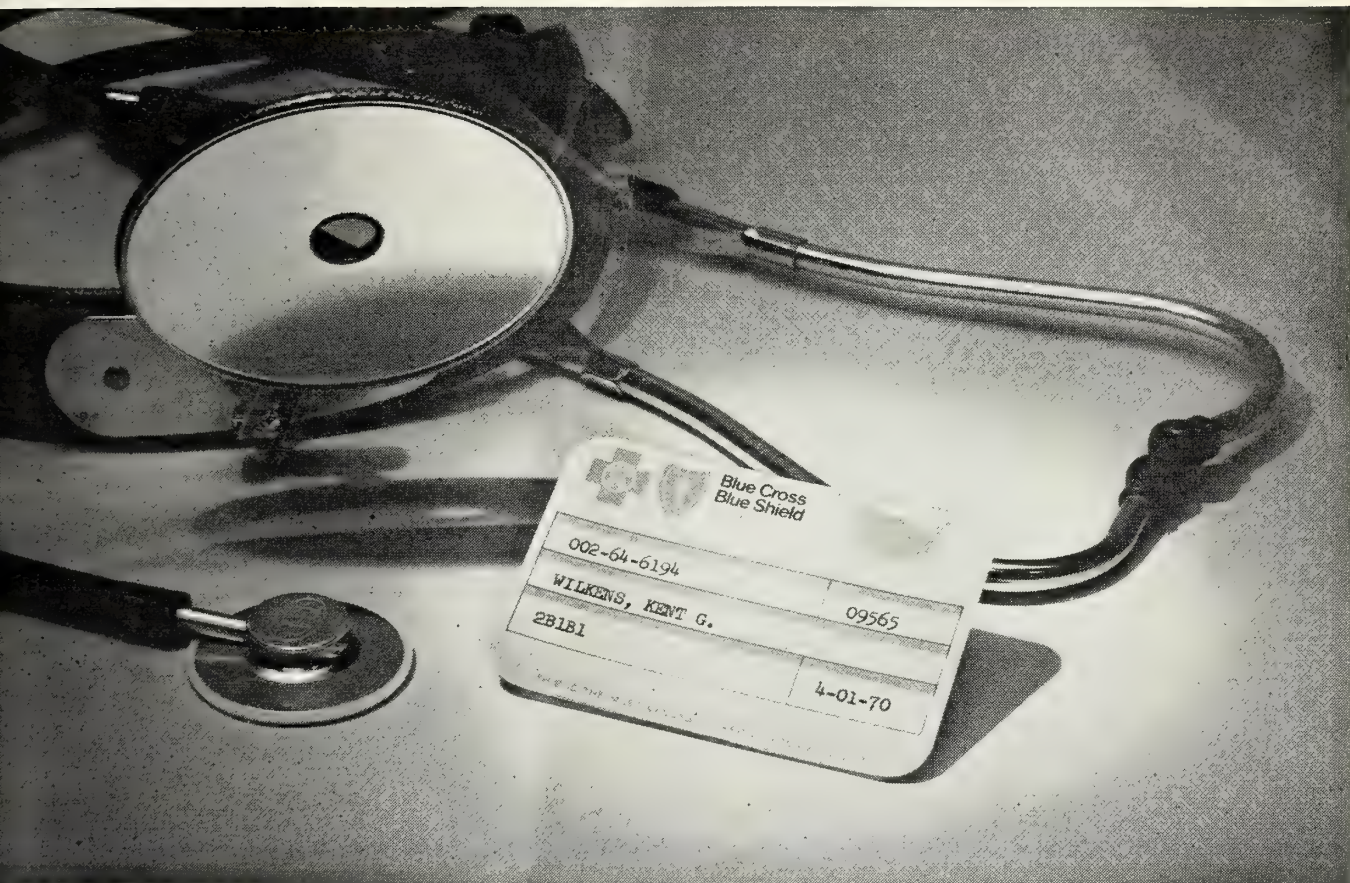
ISMA prepares the pamphlets with the titles and numbers of the tapes; it supplies the equipment, housing and labor to play the tapes requested; it furnishes one 15-unit tape deck to play the requested messages over 7 Indianapolis and 8 wide-area telephone (WATS) lines. We began the service in 1973 in Marion County under the sponsorship of grants by the Eli Lilly Foundation and RMP. The excellent reception of the program stimulated the requested statewide expansion in 1974. The expiration of the grant leaves this predicament: ISMA has initiated the services, the pamphlet begins with these words, "The doctors of your community have prepared a library of over 200 taped messages for you." One half million pamphlets have been distributed. The system averages 800 calls per day. Schools, hospitals, clinics, emergency rooms, sheriff's offices, senior citizen organizations and public health nurses make up some of the requests for Tel-Med over the entire state of Indiana. At present the only material cost to ISMA has been for new tape decks and tapes—about \$4,000.

As an organization, this has been our greatest collective contribution to public service. We have gained countless friends in keeping organized medicine's countenance as friendly as that of the patient's personal physician. My reading of the situation is that ISMA wishes to continue Tel-Med as a personal gift of each member and not as a compulsory dues increase. The total cost per year is about \$100,000, which represents a \$25 contribution per member.

A handwritten signature in cursive script that reads "Vincent J. Santare, M.D." The signature is written in dark ink and is positioned above the printed name.

Vincent J. Santare, M.D.
President
Indiana State Medical Association

Take advantage of a great association!



Get these special benefits—available with your Medical Association membership

Expanded "people-planned" protection is now part of Blue Cross and Blue Shield coverage—and you're eligible! It's one more exclusive advantage of belonging to the Indiana State Medical Association—entitling you to special group rates for these benefits:

- One full year in-hospital care
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than they are, then the prospects of freedom for the rest of the world are very dim."

DESPITE CONTINUED OPTIMISM on the part of some members of House Ways and Means that a NHI bill can be drafted this year, Capitol Hill oddsmakers are still betting it can't be done.

Besides the scarcity of time—at least 400 witnesses will be heard by Ways and Means alone—the jurisdictional battle between Ways and Means and House Commerce is far from solved.

Senior staffers of both committees are being quoted as saying "effective NHI cannot come out of a Congress with the present messed-up jurisdiction" and "it simply can't be done in two committees."

Nonetheless, the chance always remains that House leadership under the pressures of an election year could knock heads together until a hurried bill was produced.

The Administration has opposed a domestic draft of young physicians for service in shortage areas and urged congress to phase-out capitation grant support for the nation's medical schools.

Testifying before the Senate Health Subcommittee as it opened hearings on health manpower legislation Theodore Cooper, M.D., Assistant Secretary for Health at the Health, Education and Welfare Department, said:

"We are seriously concerned that the general taxpayer—by means of federal taxes—will be called upon to subsidize in perpetuity the professional training of physicians, dentists, and other well-paid health professionals."

Dr. Cooper told the Subcommittee, headed by Sen. Edward Kennedy (D-Mass.), that legislation backed by Kennedy that calls for \$5 billion in aid over the next five years is "unnecessary to elicit adequate numbers of students for schools which today accommodate only one out of every two to three qualified applicants."

The Administration "strongly opposes" the compulsory service feature in the legislation requiring all graduates to serve in shortage areas. "This requirement could mean that in the very near future the federal government would have the responsibility for placing and monitoring the professional activities of thousands of individuals in the health system." Dr. Cooper proposed, instead, to strengthen the National Health Service Corps scholarship program.

The Assistant Secretary also attacked provisions imposing a federal regulatory scheme to control the numbers and allocation of training positions for graduate medical education and to institute a national licensure system for physicians and dentists. "We feel that there is little basis for initiating this far-reaching regulatory mechanism at this time," Dr. Cooper said.

By 1985 the U.S. will have from 207 to 217 physicians per 100,000 population, he testified, placing

this nation "near the top of all the industrialized nations in terms of overall physician supply."

THE PRESIDENT OF THE AMERICAN Insurance Association believes it may become necessary to separate two elements involved in the medical malpractice insurance system—the compensation of those who suffer loss because a doctor or hospital fails to perform in accordance with acceptable standards of practice, and the incentive for, and discipline of, medical practitioners.

T. Lawrence Jones said "we think that the public will resist limitations on their legal rights unless coverage for the patient is improved in some other respect and some substitute measure for disciplining doctors and hospitals is created."

Jones, whose association includes many of the firms that write professional liability, said divorce of the two functions "will not be an easy job."

He told a National Press Club breakfast in Washington, D.C., that no one yet knows what the outlines of the two replacement systems should be, let alone the specific features of either. Many tradeoffs will be necessary. Cooperation among the professions will be essential. But the present problems with medical malpractice insurance is so complex and so full of implication for the overall health care of the public that bold solutions of all kinds must be pursued.

Jones said he believes that Professional Standards Review Organizations (PSRO's) offer a promise of ameliorating the malpractice crisis.

SCORES OF HEALTH ORGANIZATIONS have protested loudly to Congress about the red tape and inequities in the Medicare program and have urged the Ways and Means' subcommittee on health to straighten out the mess.

The Subcommittee, headed by Rep. Dan Rostenkowski (D-Ill.), called two days of hearings to consider the flood of complaints about HEW's regulatory operations over the past year. The Subcommittee is expected to draft legislation to correct some of the trouble spots identified at the hearings.

The American Medical Association declared "the continuing frustrations of the public and the economic limitations on resorting to the courts for all remedial action must be viewed seriously by this subcommittee and this Congress."

Edgar T. Beddingfield, M.D., Vice Chairman of the AMA's Council on Legislation, referring to HEW's index for figuring physicians' fees under Medicare, said "if the administrative process is to be unbridled and is to be permitted to disregard the rights of individuals and arbitrarily to establish essential factors without adequate compliance with the law, then a discussion of the provisions enacted by Congress in essence becomes moot."

Continued on page 950

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Charging "abuse of the regulatory process" by HEW, Dr. Beddingfield said effects of the economic index will be to lower reimbursement rates for many procedures below the rates recognized by the program in fiscal 1975."

The 1972 Social Security Amendments Law which set Medicare payment controls at the 75th percentile with future adjustments tied to an index determined by HEW is "clearly discriminatory," the AMA witness said. "We are not aware of any segment of society against which similar controls are imposed by Congress." Upshot of such controls, he warned, "will be to shift an increasing financial burden on the beneficiaries."

Dr. Beddingfield urged acceptance of the AMA's 19 amendments to the Professional Standards Review Organization (PSRO) program and postponement of the Jan. 1, 1976, deadline for professional associations to form PSRO's.

C. Willard Camalier, M.D., Chairman of the AMA's Council on Medical Service, described the AMA's court fight and negotiations with HEW over utilization review in hospitals. He asked repeal of the law's provisions dealing with UR on the subject of the Medicare end stage renal disease program.

Dr. Camalier said "Medicare has attempted to interfere with the practice of medicine by interposing itself between the patient and the physician by refusing to recognize that services for kidney treatment should be reimbursed in a manner consistent with other physician services, and that local determination and medical review are not only preferable, but also the only feasible program for provision of any medical service." This program emphasizes the difficulties encountered when a disease category is made the basis for Medicare coverage.

The provision authorizing HEW to mandate "rea-

sonable costs" for hospitals gives the government the right to determine in effect whether services are medically necessary, the AMA official said. "We must adamantly object to any attempt on the part of the HEW Secretary to make determinations as to the necessity of health care services required in proper patient care."

A PRACTICING PHYSICIAN HAS TOLD Congress that pending lobbying legislation would go far in discouraging valuable communications to Congress from medical professionals and from patients.

Alvin Goldfarb, M.D., St. Louis, Mo., obstetrician-gynecologist, said as a physician he has an interest in a wide range of health legislation and regulations which have "a marked influence, whether favorable or unfavorable, upon my own, as well as that of all other physicians' practice."

He told a House Judiciary subcommittee that under proposals to tighten the lobby-laws "I could be considered a lobbyist, and would have to provide detailed quarterly reports. My failure to comply could result in fines or jail sentences."

The physician said the bills define lobbying as a communication with Federal officials, either legislative or executive, to influence the policy-making process.

Said Dr. Goldfarb:

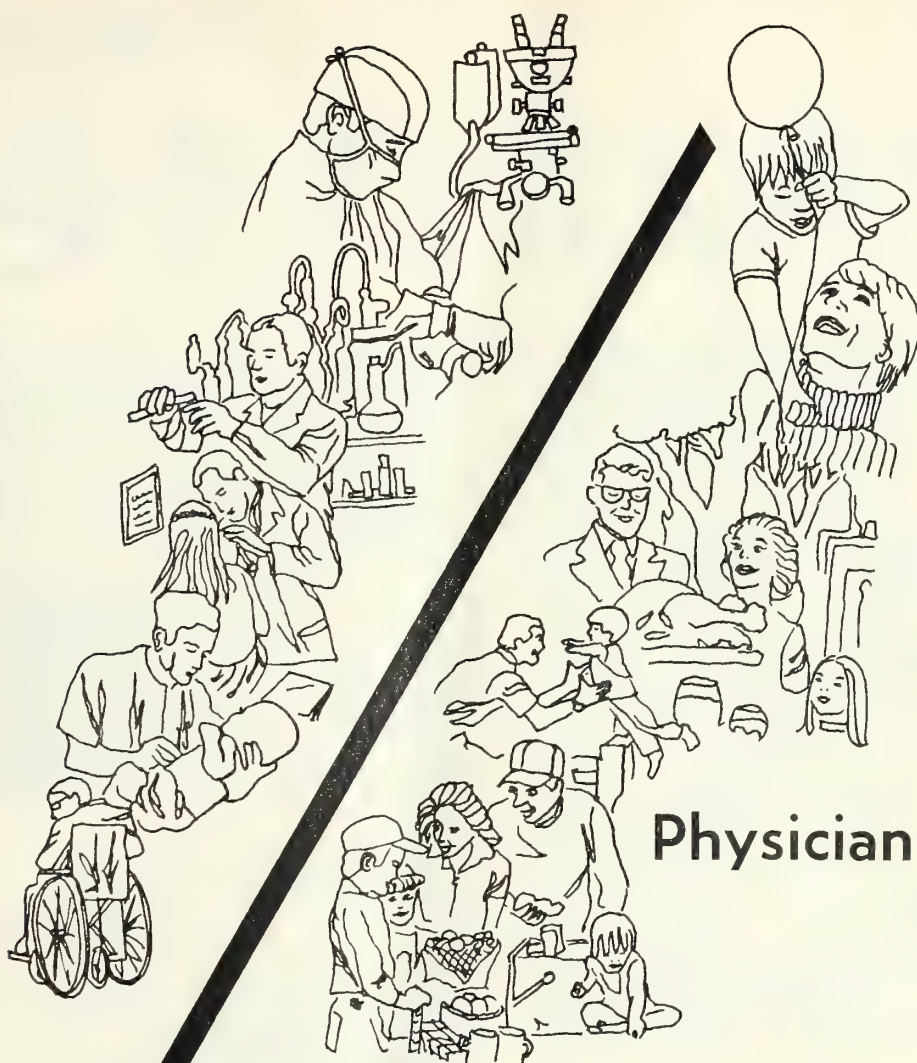
"I can assure you that I as a specialist and practicing physician have a great interest in those Federal programs that affect my practice. I have an interest not only in how they impinge on my manner of practice but also in how they affect my patients as beneficiaries of the programs.

"I feel as if it is my right as a individual, as well as my duty as a physician, to communicate with members of Congress and with the bureaucracy and at times to urge others to do so to make my voice heard in the legislative and regulatory process which will affect, either favorably or unfavorably, my practice or my patients. I am sure you would agree with me that when physicians seem to get the legislative process in order to protect or to improve the state of health care, this is a goal which should not be threatened by obstacles."

Dr. Goldfarb asked "on whom would the burden of complying really fall, the professional lobbyist or the inexperienced, non-professional individual who would be a lobbyist only because of the broad definition of the bill? Who really needs to be regulated, the person who, for pay, can lobby on any subject or a member of the public who has a vast reservoir or experience in his own field and who is willing to share this information in an attempt to assure intelligent legislation? Would I be considered a lobbyist if I urge my patients to write their Congressman concerning legislation or to the bureaucracy concerning regulations?"



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Practical Clinical Psychopharmacology: The Antidepressants and Lithium

ROBERT E. SNODGRASS, M.D.
Indianapolis

Introduction

*I*N a previously published paper we have discussed practical aspects of the tranquilizer drugs. This paper discusses the antidepressant drugs and the use of lithium carbonate in clinical medicine.

The Antidepressants THE AMPHETAMINES

The antidepressants have been found useful in treating the patient with the clinical syndrome of feelings of depression, sadness, crying spells, insomnia and often a loss of appetite with an associated weight loss.

Amphetamines and Ritalin, which is chemically related, have been used for treating depressive states. We used to describe these drugs as being cortical stimulants, but we are now beginning to understand that the amphetamines and Ritalin actually have a major role to do with the norepinephrine and dopamine metabolism of the brain. The amphetamines are generally not used as frequently for treating depression, because they tend to be abused by the patient and are also potent anorectic agents. Also, they are very rigidly controlled by Federal law. However, I have seen

patients come in complaining of feeling extremely tired and weak and exhausted. On physical examination they have either shown marked pallor of the skin or sluggish reflexes, leading me to think they were either suffering from anemia or hypothyroidism. I have been surprised to find that the blood count and thyroid tests have all been perfectly normal in these patients! Only then was I able to determine that they were suffering from a mild endogenous depression. I have found that these persons frequently respond well to Ritalin in a dosage of 5 to 10 to 20 mg q.i.d.

Paradoxically, Ritalin and the amphetamines are quite useful in treating the hyperkinetic child. We do not understand the exact mechanism for this yet.

THE TRICYCLIC ANTIDEPRESSANTS

Two fundamental tricyclic antidepressants are Tofranil and Elavil. Both are used in a dosage of 25 to 50 mg q.i.d. Care must be used in prescribing these drugs on an outpatient basis for patients who are suicidal. The suicidal patient should be hospitalized and supervised extremely closely. We must warn our patients that the drug must be taken for a sufficient period of time before the patient's symptoms will dis-

appear. A trial period of at least two weeks must be given to these patients before the drug is written off as being ineffective. It is important that we tell our patients that their depression did not develop overnight and will, therefore, not leave overnight.

Tofranil usually does not sedate the patient and, therefore, seems to be more useful in a patient who complains of feeling depressed and of wanting to sleep all the time.

Tofranil is, at times, useful in treating enuresis. It may even be useful in a child in a dosage of 10 to 25 mg q.i.d.

Elavil seems to be of more use in the depressed person who is agitated and who has trouble sleeping. It shows a sedative effect in most patients.

Other tricyclic antidepressants are available. These include Norpramin or Pertofrane, Vivactil and Aventyl. Norpramin or Pertofrane reportedly works faster than Tofranil and Elavil, but I am not certain that this has been proven.

Sinequan or Adapin fit here in this group of antidepressants. They seem to be of some value in treating anxiety as well as depression.

The tricyclic antidepressants are potent anticholinergics and may cause profound dryness of the mouth, which is particularly a

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problem in the patient who works in a job such as a telephone operator or a radio announcer. Patients should be instructed to drink as much water as possible and to chew chewing gum and to use hard candy drops liberally. Also, at times, these drugs may cause severe constipation, particularly in the hospitalized patient, and also blurring of vision. At times they may lower the seizure threshold though epilepsy is not a contraindication to using the antidepressants. At times, too, these drugs will cause urinary retention, particularly in the male who has any degree of prostatic hypertrophy. I have even seen them cause urinary retention in the female. The solution usually is to lower the dosage.

These drugs should be used with caution in a patient with acute glaucoma, though glaucoma which is under control with medical treatment is no contraindication toward the use of the drugs. Caution should be exercised in using these drugs in a patient who has a history of a cardiac arrhythmia. They certainly may cause the recrudescence of the arrhythmia, especially paroxysmal auricular tachycardia. Also, these drugs have at times, it is thought, been of some danger when used to treat the depressed patient with a myocardial infarction or the patient who suffers from coronary artery insufficiency. Be very cautious in prescribing these drugs for a patient who has had a recent coronary occlusion.

Often there is a significant degree of anxiety present in a patient who is depressed, and for this reason we commonly combine one of the tricyclic antidepressants with one of the tranquilizers discussed in a paper which appeared in the October issue of this journal.

A drug called Triavil or Etrafon has been on the market for several years. This has become useful in treating the patient who has both anxiety and depression. It is available in several combination dosages. It consists of the antidepressant Elavil and the tranquilizer Trilafon.

More and more it is becoming apparent that the major and minor

tranquilizers alone are of considerable value in treating depressed states.

MAO INHIBITORS

The monoamine oxidase inhibitor drugs also present us with an interesting background. Sometime ago a picture appeared on the cover of a national magazine showing patients who were suffering from severe pulmonary tuberculosis and who had been confined to a sanitarium in New York State dancing on the wards. A new antitubercular drug which was a MAO inhibitor showed a tendency toward promoting a sense of well-being in these terribly cachectic patients. It was then deduced that possibly a chemically related drug could be used in medicine as an antidepressant. After some research, several monoamine oxidase inhibitors were introduced into clinical medicine. The popular ones which are now available are Parnate and Nardil. These drugs should never be used in a patient who suffers from any significant cardiovascular or renal disease. Nor should they be used in a patient who has not been given a trial of psychotherapy and who has not been treated with the other antidepressant drugs. Generally, too, the patient should have had electroshock therapy.

If a patient who is taking a monoamine oxidase inhibitor ingests certain foods rich in tyramine, he may develop hypertension leading to a stroke and/or death. The MAO inhibitors may block and prevent normal breakdown of tyramine in the body, leading to the development of hypertension. Patients taking these drugs should be instructed not to eat such foods as chicken livers, raisins, figs, fava beans, sharp cheeses, certain fishes, wine, sour cream and chocolate. Also, they should be instructed not to take any other drugs unless cleared with their physician. There are some other drugs which, when combined with the MAO inhibitors, will also prevent the normal breakdown of tyramine in the body.

Patients who are taking tran-

quilizers and antidepressants should be instructed not to drink alcohol. Alcohol has been shown to potentiate the effects of these drugs. Nor should patients work around machinery or in any dangerous occupation until they are certain they are not incapacitated in any way by the drug.

LITHIUM CARBONATE

Lithium carbonate has been known in medicine for a number of years, but it was not approved for clinical usage here in the United States until comparatively recently. Lithium carbonate is the drug of choice in treating the manic or hypomanic phase of manic-depressive illness. It should be used only if the patient's physical condition warrants. The patient should not be suffering from any significant disease of the heart or kidneys, nor should the patient be on a salt-restricted diet. Also, this drug is of choice provided that adequate laboratory equipment is available in order to measure the patient's serum lithium levels. It has been found that the acutely manic patient may initially need higher dosages of lithium to control his emotional symptomatology, but that the lithium level will build up quickly in the patient. We must, therefore, watch the patient's electrolyte balance, or we can get into serious trouble. As yet, it is undecided whether lithium is of value in treating the depressed phase of manic-depressive illness. Some studies seem to indicate that lithium may at least prevent the development of further depressive episodes in the individual.

Annoying side effects of lithium are tremulousness, gastrointestinal disturbances such as nausea, vomiting and diarrhea, and general irritability and anxiety.

Conclusion

Very few new tranquilizers and antidepressant drugs have recently been introduced into clinical medicine. For a while, new psychopharmacological drugs were being introduced into the practice of medicine faster than we were able

to understand their therapeutic properties and side effects. With this lull in the introduction of new psychotropic drugs, we have finally been able to realize and assess the various indications and contraindications for the use of these drugs.

The field of biological psychiatry is becoming very challenging and exciting. We are now able to understand better the sites of action of these drugs on the brain. The limbic and the reticular activating systems of the brain have become of great importance to us as clinicians. The fields of neuroanatomy, neurochemistry, neurophysiology and psychopharmacology are becoming of even greater importance in clinical medicine. I predict that our neuropharmacologists will be able in the near future to offer us even better psychopharmacological agents for our use in the practice of medicine. The future looks most challenging and exciting and provocative.

As noted in the article published in the October issue of this journal, current research lends support to the catecholamine hypothesis of understanding depression. We are also beginning to unlock the mysteries of schizophrenia and to find that it is a biochemical problem in

DRUGS

Generic Name	U.S. Trade Name
Amitriptyline	Elavil
Amphetamine	Benzedrine
Desipramine	Norpramin, Pertofrane
Dextroamphetamine	Dexedrine
Doxepin	Sinequan, Adapin
Imipramine	Tofranil, SK-Pramine, Imavate
Lithium carbonate	Eskalith, Lithane, Lithonate
Methamphetamine	Desoxyn, Methedrine
Methylphenidate	Ritalin
Nortriptyline	Aventyl
Phenelzine	Nardil
Protriptyline	Vivactil
Tranlycypromine	Parnate

the brain with often a genetically determined predisposition. The future for the better understanding and treatment of the mysteries of mental illness and emotional disorders looks good for clinical psychiatry.

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The cases of two brothers with a Hamman-Rich type of pulmonary fibrosis are presented. Many similar cases of idiopathic pulmonary fibrosis can be identified to demonstrate a familial tendency.

A Familial Variant of the Hamman-Rich Syndrome

JAMES S. TOULOUKIAN
Indianapolis

Introduction

IN 1935 and again in 1944 Hamman and Rich described a syndrome of diffuse interstitial pulmonary fibrosis which was rapidly progressive and culminated fatally within a year of onset.¹ Since then many cases have been reported which fit the criteria for Hamman-Rich syndrome to a greater or lesser degree. Whereas the original report of this syndrome described an "acute diffuse interstitial fibrosis of the lung," subsequent reports have described a more chronic disease with the acute, rapidly progressive variety of Hamman and Rich being the exception.² Others have described a syndrome affecting only children or only adults.³ As the number of investigators reporting cases of Hamman-Rich syndrome has grown, so have the synonyms for this condition. It is now known as "fibrosing alveolitis," "diffuse interstitial lung disease" and "familial fibrocystic pulmonary dysplasia." None of these conditions can be distinguished from each other with respect to etiology, clinical appearance or pathology, with the exception of there being a genetic correlate to the latter. Since Hamman and Rich first documented this syndrome, investigators have been attempting to link certain groups of these cases to many factors including hyperglobulinemia, eosinophilia, viruses, and some type of autoimmune or collagen disease. Whether this complex of diseases represents the differential effects of the same etiologic agent on different patient

populations or the effects of a variety of causative factors on the general population remains to be determined.

In order to establish etiologies for some of these cases of idiopathic pulmonary fibrosis, it is required that we try to determine what common patterns exist. If this can be done, we will be on the road to establishing causative and/or contributing factors to some of these cases of idiopathic fibrosis which are presently lumped together under the heading of the Hamman-Rich syndrome.

Possibility of a Familial Link

In 1957 Rubin and Lubliner first suggested the possibility of a genetically transmitted variant of the Hamman-Rich syndrome.⁴ They reviewed 57 patients and found six of them to be relatives. In 1959 Donohue and his co-workers reviewed 87 cases in the literature, and they found 12 patients with a familial tendency to develop the Hamman-Rich syndrome and coined the term "familial fibrocystic pulmonary dysplasia" for it.⁵ To this group of 12 patients, Donohue added 10 cases of his own in which a familial trend was found. In one family alone, he identified seven members with a Hamman-Rich type fibrosis. In 1965 Bonnani, et al. detailed a family study in which eight members of the family had documented "idiopathic pulmonary fibrosis" and three members had findings suggestive of this syndrome.⁶ Among Bonnani's patients were two identical twins raised miles apart

who were both documented cases. On the basis of these findings it appeared possible that a particular variant of the Hamman-Rich syndrome could be genetically transmitted as an autosomal dominant with incomplete penetrance. When Koch, in 1965, reported a father-son combination, the likelihood of sex-linked transmission of this syndrome was drastically reduced.⁷ In 1966 Adelman and his co-workers conducted a family study in which a father and five siblings were all documented as having "familial fibrocystic pulmonary disease."⁸

In support of the contention that some forms of the Hamman-Rich syndrome show familial tendencies, the cases of two brothers with well documented idiopathic pulmonary fibrosis and that of a third member of the family who is suggestive of this syndrome are discussed.

Case Presentations

Case I: This patient is a 54-year-old male caucasian who was employed as a process engineer. He presented with severe dyspnea on mild exertion which had progressed from the patient's originally asymptomatic condition just one year ago to a dyspnea so severe that he could not climb a flight of stairs without resting every few steps. Associated with his dyspnea he developed a non-productive cough.

The patient had a history of whooping cough and frequent respiratory tract infections during childhood. As an adult he had had fewer infections, especially since

World War II when he was in the South Pacific and had had three or four episodes of "catarrhal fever" all of which resolved unremarkably. In 1969 he had an uncomplicated bout of acute bronchitis. In 1973 he was placed on Lasix, Lanoxin, and a potassium supplement, having been diagnosed, presumably, as having congestive heart failure. A chest x-ray at this time revealed virtually no evidence of pulmonary fibrosis.

He had a history of sand and concrete dust exposure between 1946-49 and a 35-year-history of pipe smoking. His father died of tuberculosis at the age of 39.

On physical examination his respirations were very shallow and labored. His respiration rate varied from about 22/min. at complete rest to 40/min. on minimal exertion. (His pulse at rest was 106, and his blood pressure was 116/74.) The patient had moderate clubbing of the fingernails of two years' duration, and his lips and fingernails were cyanotic even at rest. Dry crackling rales were audible in the bases of both lungs. Expansion of the chest was equal but restricted.

X-ray revealed a diffuse interstitial infiltrate compatible with pulmonary fibrosis (Figure 1). Arterial blood gases were as follows:

$pO_2=73.9$ mm Hg, $pH=7.48$, $pCO_2=41.1$ mm Hg. Pulmonary function tests revealed a vital capacity 1512 ml, residual volume 2,756 ml, total lung capacity 4,268 ml, functional residual capacity 3,350 ml, FEV (1 sec) 1,350-93 ml, and tidal volume 580 ml. Two cultures were done on sputums and subsequently obtained bronchial washings, and all were negative for pathogenic bacteria, acid fast bacilli, and fungi. Histoplasmin and second strength Mantoux skin tests were both negative. CBC was normal (RBC 4.03, Hgb 12.1, Hct 36.0) except for a +2 rouleaux formation and an ESR of 45 corrected to 32. Radial diffusion immunoglobulins were as follows: IgG 1,530 mg% (569-1919), IgM 456 mg% (47-147) and IgA 584 mg% (61-330). ANA, LE prep, and RA latex fixation tests were negative.

Lung tissue was removed on biopsy and was interpreted as showing pulmonary fibrosis, emphysema, bronchiectasis, and acute and chronic inflammation. No evidence of pneumoconiosis, other granulomatous diseases or carcinoma was seen (Figure 2). Based on the rapid progression of this pulmonary fibrosis and failure to uncover any other etiology, this case was classified as Hamman-Rich syndrome.

Case II: Hospital records were reviewed from Case I's brother and revealed the following: He was a 51-year-old truck driver when he presented with dyspnea and a non-productive cough of three months' duration. Accompanying his cough was an irritating rhinitis which he had had for many years. He was a heavy smoker (two packs a day) and had been losing weight lately due to impaired appetite. His strength was not impaired, however. He had been employed for a period of two years 15 years previously in a dusty grain elevator. He had no other history of possible dust or fungus exposure.

On physical exam the patient showed marked clubbing of both the fingers and the toes. Chest expansion was noticed to be very limited; no rales were heard in the lung bases.

X-ray demonstrated progressive bilateral pulmonary interstitial fibrosis and emphysema. No tumor cells, fungi or acid fast bacilli were identified by bronchoscopy and washings. On open lung biopsy, the diagnosis of pulmonary fibrosis and chronic inflammation was made.

In addition to these two documented cases, the patient in Case I described a cousin who had a course



FIGURE 1

CHEST radiograph at this time reveals extensive fibrosis which was not apparent on x-ray exam just one year previously.

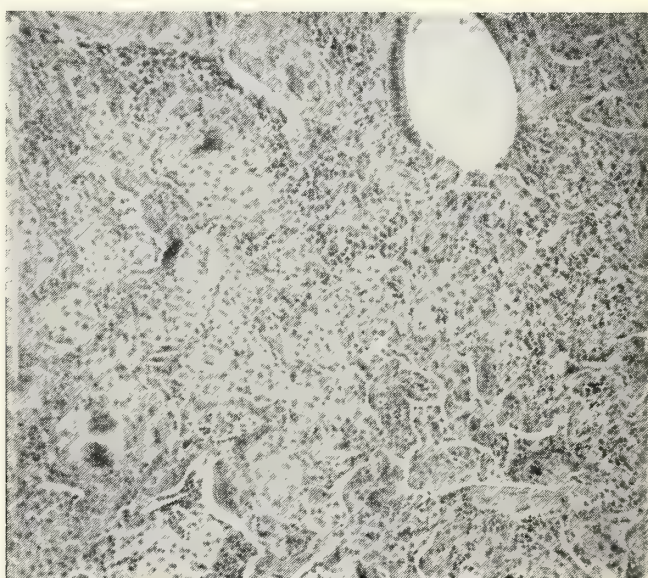


FIGURE 2

HIGH POWER view of open lung biopsy specimen showing pulmonary fibrosis, emphysema, bronchiectasis and acute and chronic inflammation.

of dyspnea very similar to his in its acute and rapidly progressive course.

Discussion

It is of interest to note that the elevation in immunoglobulins reported in Case I has also been reported by other workers in familial cases of the Hamman-Rich syndrome.^{6,8} Whether this alteration in globulins holds any promise in determining the etiology of the genetically transmitted variant of Hamman-Rich syndrome or if altered immunoglobulins are just a part of the human body's response to the disease is an interesting question.

In the cases presented here, a familial incidence of Hamman-Rich syndrome has been demonstrated. Reviewing the literature yields many more case histories similar to those presented above in which the genetic transmission of idiopathic pulmo-

nary fibrosis is clearly indicated. Although it would be premature to contend that all cases of pulmonary fibrosis are genetically transmitted, it has been shown here that there is at least one variant of the Hamman-Rich syndrome which has a familial pattern. Whether its etiology is related to an immunoglobulin and/or autoimmune factors is yet to be determined. Nonetheless, even in the absence of an etiology for this variant of the Hamman-Rich syndrome, the clinician should be alerted to the possibility of familial disease when he encounters a case of pulmonary fibrosis.

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From The Journal 50 Years Ago

Our purpose in preparing this paper is briefly to discuss some of the benefits from physical therapies which patients who have come under our observation have derived

Three general propositions concerning this subject can, we believe, be stated with confidence: first, that for some of the common diseases which physicians are called upon to treat, physical therapies are the best treatments of all, and that in the treatment of many others they are helpful; second, that the regular medical profession has neglected seriously these forms of therapy and as a result poorly trained men have profited greatly; and, finally, that since the very mention of the name physical therapy arouses in the minds of many of our profession an intense antagonism there must exist a prejudice against them which to outsiders must be incomprehensible.

There are several reasons for such a prejudice. Historically it is only a very few generations ago that our profession believed that the physician must be a gentleman, and by gentleman they meant one who would not use his hands and whose chief occupation was to philosophize. Our modern surgeons, however, have demonstrated how successfully many can recover from that idea. And, secondly, physical therapy takes time and brings but small reward. For but few physical treatments would a full-pay patient be willing to pay over \$10.00, and yet it would take more expensive equipment and about the same length of time as an appendectomy, for which the fee would be from twenty to fifty times that amount. But large fee or small fee, if physical therapy is valuable or has any exclusive virtues in the treatment of disease, our profession faces a moral obligation to develop it. We cannot afford to allow others to do so since any therapy, however good, is safe only in the hands of those well enough trained in general medicine to use it. And yet when one of the regular profession either speaks or writes enthusiastically on this subject his confreres express horror at his irregular tendencies. We do not hear them express similar horror when certain surgical operations formerly very popular are mentioned, as oophorectomy for neurasthenia, ventrofixation of the uterus in young unmarried women for backache, and shortcircuiting of the bowels for a myriad of ills; nor, when mention is made of the placebo drug remedies for troubles which should receive psychotherapy, and of polyglandular therapies for many, and vaccines or serums for all other troubles, and yet these operations and treatments have, and always have had, less foundation in truth than many of the physical therapies, and certainly have done our patients far more harm. . . . "Physical Therapy," Charles P. Emerson, M.D., Indianapolis, *JISMA*, November 1925.

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INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—September 1975

Disease	Sept. 1975	Aug. 1975	July 1975	Sept. 1974	Sept. 1973
Animal Bites	839	1327	1151	894	1122
Chickenpox	34	48	57	53	46
Conjunctivitis	217	155	150	140	317
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	29	45	35	101	188
Gonorrhea	1618	2050	1033	1163	1245
Impetigo	369	315	143	252	434
Infectious Hepatitis	51	52	42	44	61
Infectious Mononucleosis	64	45	25	68	89
Influenza	2391	1652	1133	2546	2298
Measles					
Rubeola	24	33	14	17	24
Rubella	39	46	23	41	18
Meningococcal Meningitis	3	2	1	2	1
Meningitis, Other	8	6	6	8	4
Mumps	46	33	59	21	48
Pertussis (Whooping Cough)	9	23	9	3	8
Pneumonia	284	271	178	290	419
Poliomyelitis	0	0	0	0	1
Streptococcal Infection	972	862	584	1007	1176
Syphilis					
Primary & Secondary	17	22	13	10	36
All Other Syphilis	120	143	125	109	125
Tinea Capitis	19	16	5	11	17
Tuberculosis (Active)	57	58	39	31	60

When **impotence** due to

androgenic deficiency

is driving them apart

Android®-5 MUQUETS
BUCCAL Tabs
Android®-10 ORAL Tabs
Android®-25 ORAL Tabs

Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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**NEW Teletape System
NEW Telephone Number
1-800-231-6970**

The Indiana Division American Cancer Society's Teletape System connected to the Southern Medical Association Cancer Information Center's program the first of November. Physician's who utilize the Teletape System need to note the change in telephone number.

As a result of this merging, up-to-date diagnostic and therapeutic information on specific neoplastic disease problems on taped messages, through toll-free telephone calls, are available to physicians, dentists and nurses. A catalogue of the available tapes can be requested by mailing the coupon at the bottom of this page.

USE OF THE SYSTEM

HOURS: Monday-Friday:

9 a.m.—9 p.m. (Eastern Time)

Saturday:

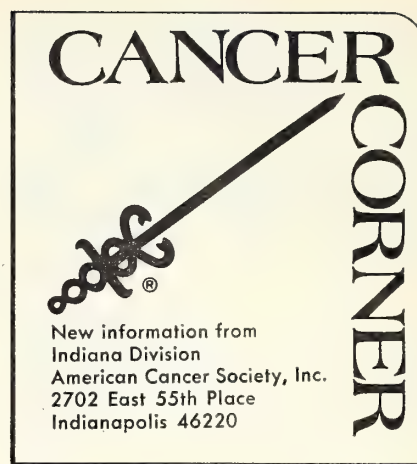
9 a.m.—1 p.m. (Eastern Time)

It is requested that if the line is busy, replace your call; identify yourself by name, address, city and state; ask for recording specifically by number; please reply to the analysis questionnaire, which will be mailed to first-time users within four to six weeks. Co-management of the Teletape System is sponsored by the Southern Medical Association and the University of Texas System Cancer Center, M.D. Anderson Hospital and Tumor Institute.

Suggested tape topics will be printed in "Cancer Corner" periodically throughout the year. The following tapes pertain to the management of the breast cancer patient:

- #769 — TREATMENT OF PLEURAL EFFUSION IN BREAST CANCER, George R. Blumenschein, M.D.
- #771 — CHEMOTHERAPY OF BREAST CANCER, George R. Blumenschein, M.D.
- #781 — THERMOGRAPHY IN THE DIAGNOSIS OF BREAST CANCER, Alfonso Zermeno, Ph.D.

- #835 — SURGICAL MANAGEMENT OF ADVANCED CARCINOMA OF THE BREAST, Charles M. McBride, M.D.
- #776 — COMBINED RADIATION THERAPY AND SURGERY FOR EARLY BREAST CANCER, Eleanor D. Montague, M.D.
- #768 — POSTMASTECTOMY SHOULDER PROBLEMS AND LYMPHEDEMA, John E. Healey, Jr., M.D.
- #775 — RADIATION THERAPY FOR LOCALLY ADVANCED BREAST CANCER, Alvah J. Nelson, III, M.D.
- #780 — XEROMAMMOGRAPHY — MAMMOGRAPHY, David D. Paulus, Jr., M.D.
- #878 — POTENTIAL ROLE OF IMMUNOTHERAPY IN BREAST CANCER, Jordan U. Gutterman, M.D.
- #778 — SURGICAL TREATMENT FOR PRIMARY OPERABLE BREAST CANCER, Edgar C. White, M.D.
- #774 — RADIOTHERAPY FOR LOCALLY RECURRENT BREAST CANCER, Norah duV. Tapley, M.D.
- #777 RADIOTHERAPY AFTER RADICAL MASTECTOMY, Norah duV. Tapley, M.D.
- #782 — EPIDEMIOLOGY OF BREAST CANCER, David E. Anderson, Ph.D.
- #772 — ENDOCRINE MANIPULATION FOR BREAST CANCER, Nylene E. Eckles, M.D., Ph.D.
- #773 — SELECTING A BREAST PROSTHESIS, Renilda Hilkeymeyer, R.N., B.S.
- #779 — PROGNOSIS OF BREAST CANCER BY STAGE OF DISEASE, George R. Blumenschein, M.D.
- #915 — THE QUESTION OF ADJUVANT CHEMOTHERAPY FOR BREAST CANCER, George R. Blumenschein, M.D.
- #942 — CHEMOIMMUNOTHERAPY OF EARLY AND



ADVANCED BREAST CANCER, Jordan U. Gutterman, M.D.

#943 — **THE VIRAL FACTOR IN THE GENESIS OF BREAST CANCER: PRESENT EVIDENCE,** Leon L. Dmochowski, M.D.

Teaching Patients Breast Self-Examination Is The Physician's Responsibility

"Standard Breast Examination" is a new professional education publication. In this pamphlet, Dr. Benjamin F. Byrd describes a technic of systematic and thorough breast examination and offers guidelines on teaching breast self-examination. Drawings, illustrating the technic, are included. To order, note the coupon on this page.

WILLIAM M. DUGAN, JR., M.D.
Vice-President, Indiana Division
American Cancer Society, Inc.

Please send one copy of the indicated pamphlets to:

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Standard Breast Examination _____

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UNORDERED MERCHANDISE

Suppose you receive in the morning mail a brand new dictionary that you haven't ordered. Enclosed with the dictionary is a bill for \$25. If you leave the dictionary on a shelf, unused, you cannot be held legally liable for the price.

But suppose you do start using it. Or give it away to a friend. Or toss it into the ashcan. Then, according to an old common law doctrine, you have "exercised

dominion" over the book and must pay for it.

Under this doctrine countless consumers, over the years, have paid for things they did not really want.

But now most states as well as Congress have passed special statutes changing the common law. These statutes usually allow the recipient of unordered merchandise to simply treat it as a gift.

This does not mean, however, that the recipient can take unfair advantage of his new privilege. Say a delivery boy leaves a carton of groceries on your doorstep by mistake. And you know perfectly well that the groceries were meant for the people next door.

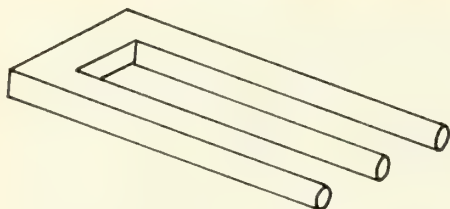
You might argue that this was "unordered merchandise," hence yours to keep for nothing. But

chances are that the statute would not be held applicable in the event of an honest mistake.

In one case a man received the annual renewal of an insurance policy from his broker. For two months he kept it, making no response. Then he informed the broker that he was not taking the insurance.

But in these circumstances, a court ruled later, the man could be held liable for at least the two months' insurance. The years of previous dealings, said the court, had justified the broker in assuming that "the retention of the policy implied acceptance."

A public service feature of the American Bar Association and the Indiana State Bar Association. Written by Will Bernard.
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Guest Editorial

A Time For Prudence

IT is time to stop blaming government, business or society for our overlong period of indulgence, and get back to what seems a completely forgotten trait of our fathers, prudence.

There is good reason for reexamining our ideas of living a life of abundance, if only because the abundance shows signs of disappearing. Depletion of raw materials has rudely awakened some people, while others slumber on. Ours is the only historical era in which we seem to have had too much, rather than too little, for our own good. Surely, our affluence has brought no special happiness or satisfactions. Further, with modern communication, the other two thirds of the world's population are no longer content to live out their lives in utter penury.

A society accustomed to affluence is unwilling to change its habits unless the force of change is all but catastrophic, as seen in the energy crisis. Without warning, a crisis was announced and voluntary sacrifices were asked. Few complied, and rumors circulated that there was no crisis, only collusion of the oil companies. Legislation was promised but little happened. The president weakened his position in saying we will be self-sufficient by 1980. Yet, the truth appears to be that in a very

few years our whole way of life will need to be changed.

Abundance seems to attenuate people's sensitivity to the need of good hygiene. It was easier to teach hygiene when times were not good. As a youngster I learned to "swat the fly," seek vaccination, drink only "drinking water," and use my legs. But our less abundant society did not learn population control, energy conservation, the danger of physical torpor for adults, the hazards of overeating and smoking, or the need to avoid quack remedies.

If we have better ways of living, how do we persuade the public to use them? Certainly we have had little success in prevailing on them to stop smoking, to exercise, to eat less, and to shun quackery, despite some very expensive educational campaigns using the fear of heart attacks, strokes and cancer as motivation. Thousands of expensive public relations experts have been able to exert more influence in Congress than they have with the public.

Having failed, we have turned to "celebrities" for their help. They do get people's attention as opposed to medical societies, voluntary health agencies and government. I am sure Dr. Marcus Welby's medical views have more impact than those of our best doctors. When family health wants a message told, they call on people in the public eye—Cronkite, Walters, Carson, Cousins, Rudel, Cavett, Rockefeller, Javits,

Trudeau and Douglas. Only two physicians are mentioned, and they are as nothing compared with a Marlene Dietrich or an Ann Landers.

Television has made possible the "educational" clout of celebrities, but it is subject to wide abuse. Instead of instilling good hygiene, my TV screen urged me, in quick succession, to take an antacid because I ate too well, a pain reliever for my headache or arthritis, a tranquilizer to face a meeting with my company president, a laxative because I was off schedule, and a hypnotic to help me sleep—the worst possible hygiene for an already overmedicated society. Clearly, we urgently need ways of persuading people to do the things that are lifesaving.

Much education in hygiene comes from the news media, especially television. Cultism is allowed to flourish. Recommendations for the use of all manner of drugs are permitted with a laxness that would not be tolerated by physicians of the Food and Drug Administration. (Parenthetically, so stringent have some prescribing guidelines become that therapy is in imminent danger of being controlled by government, especially through non-reimbursement of the Medicaid patient for use of a drug in unapproved form).

The ubiquitous vending machine has made unhygienic eating all too

easy and has destroyed any sense of food values, both caloric and financial. Faddism is exaggerated by rapidly changing social mores, especially of the young. It is difficult to separate the good from the bad. Extreme diets have led to severe malnutrition.

For anyone who is skeptical of the enormous power of the printed word on people's diet, read the book review section of any newspaper. New, exotic, and downright dangerous diet recommendations thrive, no matter how many are currently in vogue.

The average American has lost his sense of prudence, which has led him to profligate waste. We have even been urged to waste in order to ensure employment and profits. This has led directly to excessive automobile driving with its attendant 56,000 deaths a year, plus 5,800 serious injuries daily. Is this kind of abundance healthy? Because food was cheap, our buying habits became unspeakable. Children are fed on snacks, candy bars, soft drinks, pork sausage, and other "lethal" mixes. And need I mention exercise?

But how about doctors? The public should look to us as examples of hygienic living. Instead, they see mirrored their own indifference, often in an exacerbated form. How many times have you heard people say that doctors commit many more hygienic sins than they themselves do? Doctors simply are not expected to misbehave, and the public is right!

What do we do about it? Editor James Reston has this to say; "We need to cut down, slow up, stay home, run around the block, and read a book once in a while." Very good sense but not quite enough.

We must recover from the prosperity from which we have suffered. Shortages of oil, beef and paper probably will help more than hurt us. The remedies for our bad habits with their risks to life are obvious enough. But if doctors are to act as good examples, we must restore the public's confidence that

good hygiene makes good sense and good living.

I have not mentioned stress as an important hygienic factor because it is so difficult to say anything new about it.

It is impossible to categorize rigidly harmful stresses because the effect depends on the reaction of the person. Silence is golden to some and frightening to others. Death is a relief and joy to some and fearful to others. Great heights are alarming to me and exhilarating to others. Even the response to stress changes with age and physical state. What seems to be unbearable rhythmic noise to us stimulates and soothes the young.

Physicians should have an important part in attenuating the effects of stress. Listening is the first requisite—listening instead of writing a prescription. You must be worthy of the trust placed in you for a maximum anti-stress value. If you have not listened, the most essential bulwark against the stress of fear—namely, hope—can never be restored. To destroy hope for whatever reason is both cruel and unnecessary. It matters not whether the hope is for a possible cure or improvement in health, for eternal oblivion, or for a better life hereafter. I do not know what mental health is, but I know what hope is and so do you.

If this sounds fatuous, it does work for quacks who do little more than restore hope and confidence. Ask yourself why a Dr. Jacobson in New York can give amphetamine injections to a host of celebrities, regardless of common sense, medical advice, or even the need to obey the law.

Stop blaming the government, business and society for our inability to cope with prosperity. Heaven knows they have their serious faults, but the public must learn what to take and what to leave of the many things so invitingly offered "for sale." Discipline in its broadest sense begins in childhood. It is the long-term ideal and may never develop or may be arrested early by indulgence.—**Herman M. Baker, M.D., Evansville.**

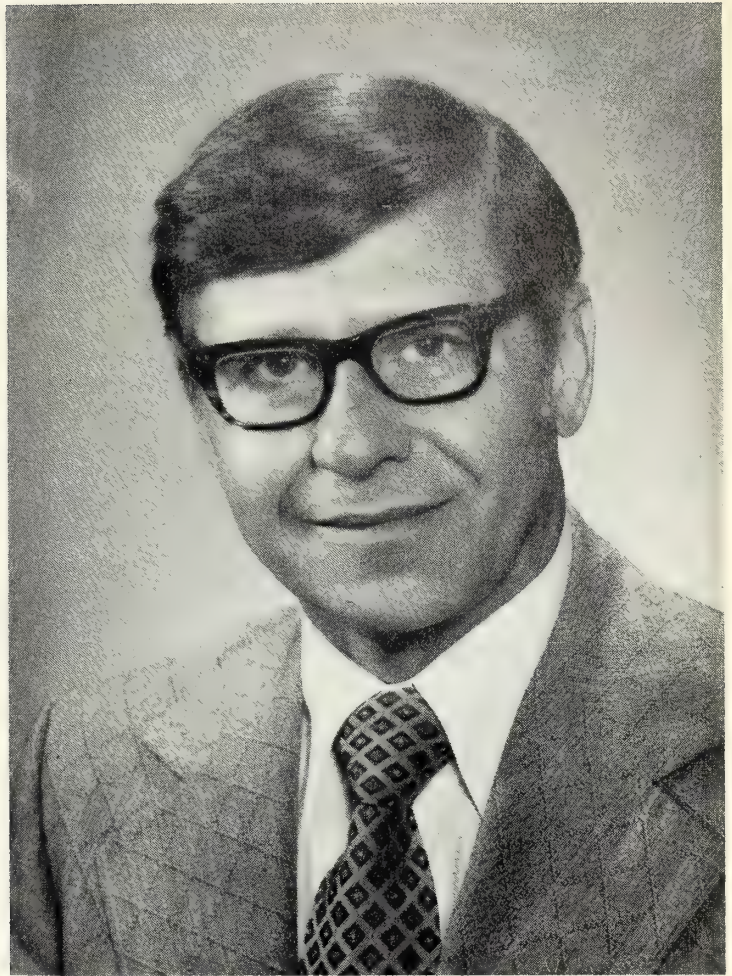
Editorial Notes . . .

The VA medical service has found that good nutrition will not protect the liver of heavy drinkers. Recent studies show that alcohol directly produces liver diseases, an effect which is separate from the dietary deficiencies suffered by alcoholics.

When the world shifted from wood to coal in the 19th century and from coal to oil and gas in this century it required about 60 years in each instance to reach maximum use. The Energy Research and Development Administration is reminding Congress that the present shift from oil and gas to a new form of energy must be accomplished in a much shorter period of time.

The St. Joseph County Medical Society is sponsoring a public information program called "Operation Neck Check" to acquaint the public with the problem of occasional cases of thyroid nodules which develop years after x-ray treatment of the neck in infants and children. Everyone who knows of having received such treatment when young is being urged to visit his physician for a thyroid examination since some of the nodules are cancerous. The news media are assisting with newspaper articles and television programs.

The absolute necessity of having bioequivalent preparations of digoxin has been demonstrated beyond a shadow of doubt. Even the FDA has finally listed digoxin as having equivalence problems. However, when politics gets mixed in with the drug problems, anything can happen. New Jersey has digoxin on its interchangeable list and will pay only for "the four cheapest available sources." Not so long ago one of the chemically equivalent forms of digoxin produced a blood level one-seventh of that produced by the reliable form. ◀



VINCENT J. SANTARE, M.D.
President
Indiana State Medical Association
1975-76

DR. VINCENT J. SANTARE, Munster, succeeded to the office of president of the Indiana State Medical Association during the recent Annual Convention in French Lick.

Dr. Santare is a native of New York State and is a graduate of the Long Island Medical College (now titled State University of New York Downstate Medical Center, New York-Brooklyn). He interned and was a resident at the Long Island College Hospital, where he trained as a urologist. He is a diplomate of the American Board of Urology.

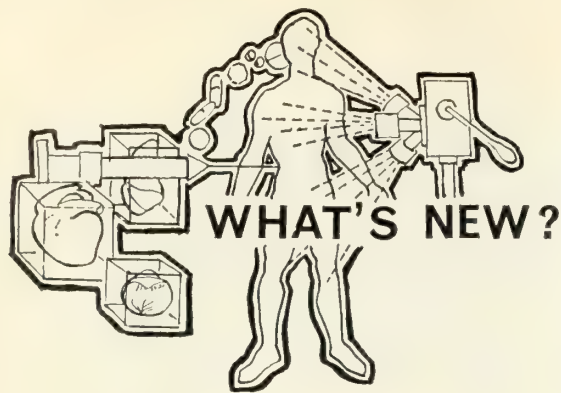
He was licensed in Indiana in 1953 and has practiced his specialty in Lake County since then.

Dr. Santare has always been active in organized medicine. He has served as president of the Lake County Medical Society, and as president of the medical staff of St. Margaret Hospital, Hammond.

He represented Lake County as delegate to ISMA starting in 1965. He was elected councilor (later trustee) in 1971. He was seated on the ISMA Executive Committee in 1972 and served as chairman of the Board of Trustees in 1973, following which he was chosen president-elect.

Dr. Santare is known for his community interests which are many and varied. He has served as treasurer of combined United Funds in his area for many years. In 1966 he was named "Volunteer of the Year."





Teletronics of Australia is introducing to the USA the world's smallest pacemaker. It's weight, 55 grams, makes it less than half the weight of the lightest of its contemporaries. It is powered with Lithium and is available in asynchronous and ventricular inhibited models.

* * *

Lexington Books announces publication of "Public Policy and the Smoking-Health Controversy." The author is Kenneth Friedman, assistant professor of Political Science at Purdue. The book considers the hotly contested issue of profit motive versus public-health interest and the resultant impact upon government policy. Priced at \$15.

* * *

Dell Publishing announces a new book "How to be Cellulite Free Forever." Complete explanation on what it is, how to avoid it, how to get rid of it and how to pronounce it (sell-you-leet). Priced at \$1.50. Now that fat and flab tend to be words to avoid, cellulite is the polite term.

* * *

The American Insurance Association, 85 John St., New York City 10038, has two charts for sale. They analyze the results of 1975 legislatures in regard to malpractice from Jan. 1 to June 30, 1975. Charts are available at \$2 a set. Supplements will be issued as appropriate and sent to buyers without additional charge.

* * *

Sherwood Medical has a new Argyle Ferguson Thoracic Catheter. It is radiopaque Sentinel Line which bisects the drainage eyes to facilitate accurate placement. Also contains a malleable wire insert in its wall to aid in placement and to insure that the catheter will stay in position without painful pleural fixation sutures.

* * *

Fischer X-ray has introduced a new mammography system called Astrixmammograph. It is suitable for Xerox cassettes and has a compression device which is independent of the x-ray tube.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or Narcan® (naltrexone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: **Lomotil is contraindicated in children less than 2 years old.** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

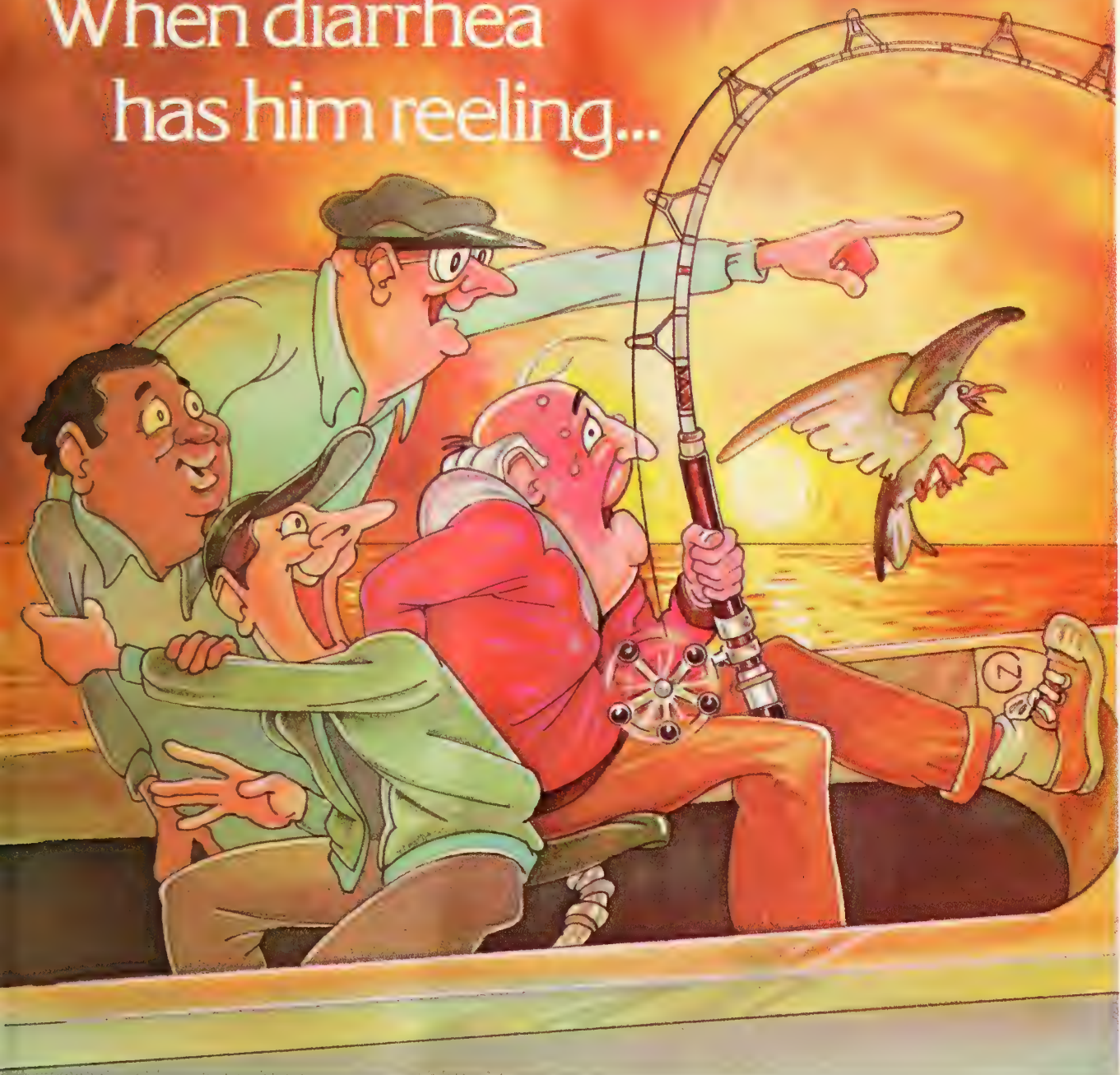
Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Lomotil is contraindicated in children less than 2 years old.

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a unique antihypertensive agent

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders. It is not recommended in pheochromocytoma. It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

to further
simplify therapy
for many patients

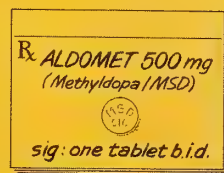
now available
ALDOMET® 500 mg
(METHYLDOPA|MSD)

- often more practical to prescribe
- easier for patients to remember

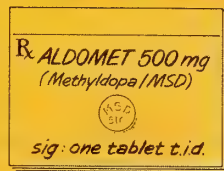
Now offered in addition to the standard 250-mg tablet, the new ALDOMET 500 mg tablet is a patient convenience. An especially important one, since in hypertension convenience of the dosage schedule is one factor that can make the difference in compliance of the patient. The minimum daily dose of ALDOMET is 250 mg b.i.d. The usual starting dose is 250 mg t.i.d. Dosage is adjusted as necessary by adding or deleting 250 mg or 500 mg at intervals of not less than two days. The maximum dose is 3.0 g per day.

Examples of b.i.d. or t.i.d. dosage convenience provided by ALDOMET 500 mg within the usual daily dosage range of 500 mg to 2.0 g:

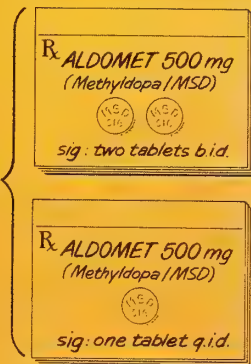
1.0-g
daily
dose =



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dose =



2.0-g
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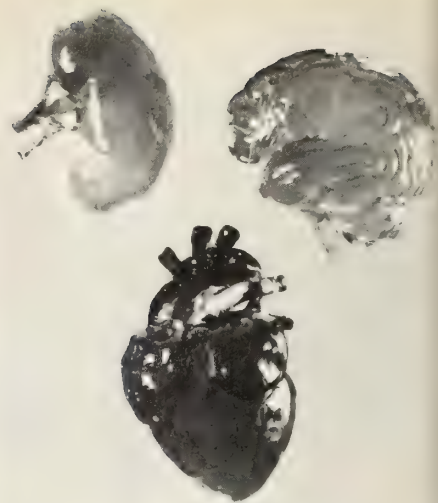
MSD
MERCK
SHARP
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NOTE: Tablets shown are not actual size.

in hypertension

ALDOMET[®] (METHYLDOPA|MSD)

usually lowers blood pressure effectively



Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyl dopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyl dopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyl dopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyl dopa. If a positive Coombs test develops during methyl dopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyl dopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyl dopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyl dopa, the drug should not be reinstituted. When methyl dopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyl dopa is stopped.

Should the need for transfusion arise in a patient receiving methyl dopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or

cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyl dopa. If caused by methyl dopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyl dopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyl dopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyl dopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyl dopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressor. Hypertension has recurred after dialysis in patients on methyl dopa because the drug is removed by dialysis procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease in blood pressure on standing). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyl dopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatulence, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensive other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Since tolerance in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyl dopa each, in bottles of 100; Tablets, containing 250 mg methyl dopa each, in single-unit packages of 100 and bottles of 100 and 1000. Tablets, containing 500 mg methyl dopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your most representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD MERCK SHARP & DOHME



Selections on Medical Education

Learning Resources

IT has been suggested that the most appropriate educational stimulus is the professional situation itself—in the case of the physician, this stimulus is the problem of his patients.

In an article written at the new medical school of McMaster University in Canada, Neufeld and Spaulding state, "we believe that medical students who become independent and efficient self-directed learners during their undergraduate careers will maintain their own continuing education throughout their professional careers." In pursuit of the development of such students, the authors describe their experience in the faculty of medicine with a range of learning resources. They choose to discuss learning resources as those for information and those for problem-solving. In the first category, they find the printed page remains the chief source of information. A book is readily available, portable, versatile and relatively inexpensive. For flexibility and efficiency, the printed page is unsurpassed as a learning resource. As an aside, the writers note that "the lecture has been largely abandoned as a method of giving information."

In the area of audio-visual resources, predominantly slide-tape

presentations, they find students prefer those presentations which encourage them to participate actively, to think critically, and to anticipate feed-back. Often various combinations of scripts, slides, audiotapes and film are used. Morphologic demonstrations include plastic-embedded pathologic specimens and predissected anatomical specimens. Most of these audio-visual resources are available in the health sciences library. They may be moved to a "learning laboratory," where they are available through the 24 hours.

In the McMaster program, problem-based learning is a fundamental educational approach. The authors feel this emphasis results in increased retention of information, is more motivating and enjoyable to students, enhances critical thinking, and more closely resembles "real life learning." By first attempting to define the dimensions of a problem, a student is more aware of what information he needs and can proceed to get it. To encourage this type of problem-based learning, several kinds of additional learning resources for problem-solving are available. Through early introduction to patients in various health care delivery settings, students are encouraged to focus their studies on the problems of patients.

Because actual patients may not

always be available at a given time and place, or for a specific purpose, the faculty have increasingly turned to the use of simulated patients—that is, normal persons who have been trained to simulate the clinical features of an actual patient. More about this later.

Another educational tool is the use of computer-based problem-solving exercises. The student is presented with basic clinical data about his "patient" and may ask for further clinical or investigative information. He then proceeds to administer various forms of treatment and receives feedback about the physiological and clinical effects of his manipulations.

Some of the following generalizations from their studies are, "there is a wide range of study patterns among students; for the acquisition of information, readings are the most extensively used resource; as students progress through the programme, they become more discriminating and efficient in selecting and using various resources; resources which provide problems and require active thinking and participation are preferred to those where the student just sits and listens."¹

Simulated Patients

In 1974, Dr. Howard Barrows, a neurologist from the medical school of McMaster University, visited London to conduct a two day workshop on simulated patients arranged by the Department of Audiovisual Communications of the Board of Science. A subsequent editorial in the *British Medical Journal* stated that the simulations of illness were highly convincing. Further, the writer of the editorial suggested although the use of simulated patients might not appeal immediately to British clinical teachers, there were a number of clinical situations which need delicate handling, such as, the care of the dying, or if patients have severe or unusual disturbances of mood or behavior; problems may also arise when asking questions of a highly personal nature or in dealing with patients who are hostile or sex-

ually threatening. The editor went on to say, "Clearly students must learn to handle such situations, and it seems common sense to allow them to practice their parts in conditions in which no damage can be done. For this purpose simulated patients would be excellent substitutes." Despite the major problems having to do with logistics, it was thought some of the 13 medical schools represented at the workshop may well decide to assess the use of simulated patients in their own environment.²

Objective Structured Examinations

"Despite the increased interest in assessment procedures in medicine and the wide use of objective techniques in written examinations, the clinical examination has remained largely unchanged." So begins a paper by R. McG. Harden, et al. which recently appeared in the *British Medical Journal*. They mention that in the traditional clinical examination the student's competence is usually assessed by two examiners who test his skill on a few patients. "Thus," they say, "the luck of the draw plays too dominant a part in the procedure, and variation in the marking standards between examiners may be conspicuous." Because

of this and the fact there is often confusion about what is being tested, the authors describe a structured clinical examination which, they believe, avoids many of the disadvantages of the more conventional methods of assessing clinical competence. During the examination in the hospital ward the students rotate round a series of stations, at each of which he spends five minutes. At one station they are asked to carry out a procedure, such as take a history, undertake one aspect of physical examination, or interpret laboratory investigations in the light of a patient's problem, and at the next station they have to answer questions, open-ended or of the multiple-choice type, on the findings at the previous station and their interpretation. Students may be observed and scored at some stations by examiners using a check list. An examination consisting of 16 stations can be completed in 85 minutes and, with two complete rotations, 32 students can be examined in a morning.

In the structured clinical examination two variables, the patient and the examiner, are more controlled and, according to the author (Dr. Harden, Head of Division of Clinical Medical Education at University of Dundee), a more objective assessment of the student's clinical

competence is made. Further, the article points out, it is possible to control the examination's complexity and to define more clearly what skills, attitudes, problem-solving abilities and factual knowledge are to be assessed. The examination is more easily repeatable than the traditional clinical examination and standards from year to year may be more easily compared. Finally, because the structured clinical examination provides feedback to the staff and to students, it is useful in directing further studies for the students and in designing teaching programmes for the staff.

It is interesting to note that in the last line of their paper they, too, mention simulated patients, saying "the use of simulated patients also helps to spare any annoyance, inconvenience, or discomfort to patients."³

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1. Neufeld, V.R., Spaulding, W.B.: Use of Learning Resources at McMaster University, *Brit. Med. J.* 3:99-101, 1973.
2. Simulated Patients, editorial, *Brit. Med. J.* 2:399-400, 1974.
3. Harden, R. McG., Stevenson, M., Downie, W.W., Wilson, G.M.: Assessment of Clinical Competence Using Objective Structured Examination, *Brit. Med. J.* 1:447-451, 1975. ◀

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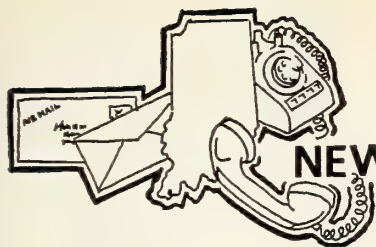
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B. Paid circulation.		
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D. Free distribution by mail, carrier or other means, samples, complimentary, and other free copies	177	170
E. Total distribution (Sum of C and D)	4,806	4,850
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1. Office use, left-over, unaccounted, spoiled after printing	54	50
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I certify that the statements made by me above are correct and complete. James A. Waggener.



NEWS NOTES

Idaho Supreme Court to Settle Issue As to Maximum Limits on Liability

An Idaho trial court declared that setting maximum limits on physicians' liability is unconstitutional. After passage of the state's professional liability law containing maximum limits, the Idaho Medical Association sought an advisory decision by the state's Supreme Court on the constitutionality of the provision. The request was rejected. In a case before the trial court, the maximum limit provision was declared unconstitutional. The case will now be appealed to the Idaho Supreme Court.

On Pediatric Academy Program

Five physicians affiliated with the Indiana University School of Medicine were leaders in roundtables and seminars at the annual meeting of the American Academy of Pediatrics in Washington, D.C., last month. They are Drs. Thomas V. N. Ballantine, **Donald A. Girod**, **Eugene M. Helveston**, Arthur L. Norins and **Jay L. Grosfeld**.

Ames Starts \$4 Million Addition

The Ames Company Division of Miles Laboratories is starting construction on a \$4 million addition to the Administration and Product Development Building in Elkhart. Research will be directed mainly to the clinical diagnosis field.

Dr. White New Heart President

Dr. Douglas H. White, Indianapolis, has been named president of the American Heart Association, Indiana Affiliate, Inc. The announcement was made during the 27th Annual Meeting and Scientific Session of the Heart Association at Indianapolis recently.

Medical Assisting Program Accredited

Indiana Vocational Technical College at Madison has been granted accreditation for its medical assisting program. Graduates will receive a one-year certificate. The program provides a basic knowledge of anatomy, physiology, medical terminology, medical law and ethics, human relations, bookkeeping, insurance, administrative, laboratory and clinical procedures.

Dr. Lopez to Assume IPMA Presidency

Dr. Filemon Lopez, Dyer, will be installed as president of the Indiana Philippine Medical Association at the inaugural dinner and ball which will bring to a close the organization's 5th Annual Scientific Assembly and General Meeting which will be held at the Admiral's Convention Center, Merrillville, on Nov. 15 and 16.

Mrs. Luis Advincula, Brazil, will be installed as president of the IPMA Auxiliary. This will be the 4th Annual Meeting of the woman's auxiliary.

Dr. Lowell Steen, Hammond, will be the guest speaker at the inaugural dinner.

PMA Makes Clinical Pharmacology Grants

The Pharmaceutical Manufacturers Association Foundation reports \$667,000 in grants in 1974 to 37 individuals through the six research and educational support programs. The program is devoted to support of clinical pharmacology in its educational and research aspects. **Dr. August M. Watanabe** of Indiana University is the recipient of continuing annual awards in the clinical pharmacology faculty development program.

Dr. Joseph McPike Nominated

Dr. Joseph D. McPike, formerly a resident of Indiana and a pioneer in hospital emergency room service, and now director of the Emergency Department at Winter Haven Hospital, Florida, has been nominated for election to the Board of Directors of the American College of Emergency Physicians.

Sandoz Announces Journal Awards

Sandoz Pharmaceuticals has conducted three workshops for staffs of medical journals and plans to conduct at least three more. The free workshops are held on a regional basis for the purpose of aiding staffs to improve design and readability of medical publications.

In addition to this, Sandoz announces the Sandoz Medical Journal Awards. These will be awarded in four categories for outstanding appearance and editorial content. The four categories are state journals above and below a circulation of 3,000 and county and city journals above and below a circulation of 2,000. Each publication cited will receive \$500 and a plaque.

Continued



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NEWS NOTES

Continued

Record Number Pass CMA Examinations 67 from Indiana Attain Certification

A record number of candidates have passed the 1975 certification examinations of the American Association of Medical Assistants. A total of 1,338 CMA certificates will be awarded. Sixty-seven Indiana medical assistants won certificates, either Basic (CMA) Administrative (CMA-A) or Clinical (CMA-C). All are entitled to the CMA designation except those earning the specialty category designation, as indicated.

Sandra K. Fife, Brighthurst; Emily E. Ross, Brownsburg; Carol A. Grubaugh, Carmel; Elyjahta A. Jahn, (CMA-C) Carmel; JoAnn G. Cummings, Cutler; Susan Ives, Delphi; Cheryl Lynn Kennedy, Elkhart; Norma Lee Bodkins, Evansville; Mary Elizabeth Hobbs, Franklin; Cheryl Ann Griffin, Galveston; Joyce B. Graybill, Goshen; Debra Jean Johnson, Goshen; Janice L. Vanhook, Greenwood; Cydney Marie Parent, Hobart.

Also Barbara J. Boyd (CMA-C), Sandra Jean Boyd, Lorraine Claybrooke, Flora Banke Dula, Marguerite Fitzgerald, Cheryl L. Hammond; Martha V. Jennings, Carolyn S. Ludwick, Rebecca Lea Mathews (CMA-C), Barbara L. Medlicott, Pauline H. Pinnick, Connie S. Rice, Lynn Ann Roy, Pamela Ann Sandhoff (CMA-C), Donna Kay Settles, Roxie Ray Shannon, Mary Walker, Gail Ann Winburn, all of Indianapolis.

Other Hoosiers attaining certification are Sara Sue Nieman, Jeffersonville; Catherine Lea Fox, Jonesboro; Karen Beth Kindig, Kentland; Ingrid G. M. Ashburn, Kokomo; Monita K. Clark, Kokomo; Sandra Kay Shuck, Kokomo; Claire A. West, Mishawaka; Edna M. Reed (CMA-C) Nappanee, Virginia Jane Scott, New Albany; Sandra Faye Lee, North Liberty; Cheryl M. Rowe, North Vernon; Debra R. Vaughn, Onward; Pamela L. Newhouse, Ossian; Julie J. Hess (CMA-C) Plainfield; Terri L. Buschman, Reynolds; Carla Jann Heck, Rushville, JoAnn Johnson, Sharpsville; Cynthia L. Krise, Shelbyville.

In addition, these medical assistants passed the exams: Laurel Sue Annis (CMA-A), Carol Ann Bogol, Pamela Ferguson, Georgann Kantorowski, Sheryl Lybarger, Donna Leora Nick, Kathryn Ann Niezgodski, Karen Kay Poyser, Betty Reif, Esther M. Robar, Sharon L. Wallis, all of South Bend.

Also Kay Lynn Strombeck, St. Joe; Beverly M. Banschbach, Valparaiso; Juanita M. Colbert, Valparaiso; Nancy A. Carter, West Lafayette; Jeanna Mae Evans, West Lafayette, and Claudia E. Kochell, West Lafayette.

AMA Incorporating Reinsurance Company

Incorporation of an AMA professional liability reinsurance company was recently authorized by the Board of Trustees. The facility will be known as the American Medical Assurance Co. Before the company can become operational, \$1 million in capital and \$1 million in surplus will be required as funding, and arrangements must be completed with state medical societies participating in the program. The purpose of the AMA company will be to provide increased capacity, added capital, and technical assistance to local society insurers writing primary professional liability insurance directly to physicians.

Medical Assistants Elect Bettye Fisher

Bettye J. Fisher of Evansville has been elected secretary of the Curriculum Review Board of the American Association of Medical Assistants. The AMA Council of Medical Education, in collaboration with the Curriculum Review Board, has been recognized by the U.S. Commissioner of Education as an official agency to accredit education programs for medical assistants.

New Deputy Coroner for Allen County

Dr. Raymond S. Beights was recently appointed deputy coroner for Allen County by Coroner **Roland C. Ahlbrand**. A current full-time emergency room physician, Dr. Beights was formerly in family practice.

Free Film on Resuscitation Offered

The Advanced Coronary Treatment Foundation (ACT) announces a 14-minute, color, motivational film on why all citizens should learn cardiopulmonary resuscitation. The title is "A Life in Your Hands." It is narrated by Burt Lancaster. The Foundation recommends that everyone 13 years of age and older should have a short course in resuscitation. To obtain free loan of film together with a Leader's Discussion Guide and other collateral materials, write West Glen Films, 565 Fifth Ave., New York City 10017.

Indiana Roentgen Society Elects

Officers for 1975-76 have been elected by the Indiana Roentgen Society—Radiology Section, ISMA, as follows: **Dr. David C. Gastineau, Fort Wayne, president; Dr. Roscoe E. Miller, Indianapolis, president-elect; Dr. John A. Knote, West Lafayette, secretary, and Dr. Edmond A. Franken, Indianapolis, treasurer.**

Drs. Edwin F. Koch, Jr., Muncie; Charles Helmen, Indianapolis, and Gerald Kurlander, Indianapolis, will serve as councilors, while **Drs. Theodore L. Megremis, Bloomington, Joseph Wind, South Bend, and Donald Zalac, Michigan City,** will serve as alternate councilors.

Tuberculosis Workshop for Nurses

Dr. J. Frank Stewart, Vincennes, was the principal speaker for the workshop titled "Tuberculosis: Yesterday, Today and Tomorrow" presented recently at Huntingburg for the registered nurses and licensed practical nurses of the area.

Gives Up Obstetrics after 11,434 Babies

Dr. Frank Wood Peyton, Lafayette, who has practiced at Lafayette from 1937 to July 1, 1975, was the subject of a feature article in the *Lafayette Journal and Courier* recently. The occasion was the party honoring Dr. Peyton's retirement from obstetrics; he will continue with his gynecology practice.

"Grand Rounds" on Closed Circuit TV

"Grand Rounds In Surgery," the new closed-circuit telecast on WAT 21 from I.U. School of Medicine is scheduled at 12 noon (Indianapolis time) the first Wednesday of each month. The Dec. 3 program will be on Surgical Therapy for the Thyroid Nodule. Subsequent broadcasts will be on Jan. 7, Feb. 4, Mar. 3, Apr. 7 and May 5. Topics for presentation may be suggested by writing Dr. Thomas V. N. Ballantine, 1100 W. Michigan St., Indianapolis 46202.

Will Study "Lung in Shock" at Muncie

The Muncie Center for Medical Education at Ball State University has received a grant of \$20,935 for the study of "The Lung in Shock: The Pathobiology of Respiratory Insufficiency." **Dr. Anthony Dowell,** internist and director of the Center, will work with Professors Thomas Lesh and Mohinder Jarial and Dr. Douglas Triplett, Muncie pathologist. An attempt will be made to identify and prove the cause of "shock lung."

AMA Receives Federal Grant

The AMA received a grant for more than \$448,000 from the federal Law Enforcement Assistance Administration to develop a national accreditation program for jail health care facilities. The one-year grant will help the AMA develop a set of guidelines for minimum standards to inmate health care. Once the standards are developed, they will be tested in the jails of six states, with the help of the medical societies in those states, leading to the establishment of a national accrediting system.

Presents Diabetes Management Course

Dr. David A. Sorg, Fort Wayne, was a lecturer at the recent five-week course on the understanding and management of diabetes presented by the Visiting Nurse Service of Fort Wayne.

Dow Chemical Co. Expanding

Dow Chemical has recently combined its health and consumer products related businesses into a single management group called "The Health and Consumer Products Department." The three components are Dow Consumer Products, Dow Pharmaceuticals and Dow Diagnostics. Headquarters for the group will occupy a 350-acre site in northwest Indianapolis. Construction of a \$9 million facility for pharmaceutical research will be completed soon. An administrative center is planned for the near future.

Continued

Prosthetic Care for the Medicare Patient



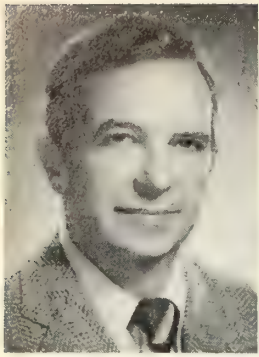
When medically prescribed, the Medicare program will assist the patient in purchasing a prosthesis, provided he is covered under Part B of Medical Insurance. All Hanger offices throughout the United States provide services under the Medicare program.

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For further information on prosthesis for the Medicare patient, please write:

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312 E. McMillan St., Cincinnati, Ohio 45219
416 N. Main Street, Evansville, Indiana 47711
3004 S. Wayne Ave., Fort Wayne, Ind. 46807



Dr. John W. Beeler, who was named the first speaker of the House of Delegates of the Indiana State Medical Association at the 1973 Annual Meeting, was elected president-elect at the meeting at French Lick last month. A radiologist in practice in Indianapolis since 1950, Dr. Beeler has served on numerous committees and commissions and has

been a delegate from Marion County for many years. He was graduated from the Indiana University School of Medicine in 1944, interned at Philadelphia General Hospital and was a resident at the Mayo Clinic. In addition, Dr. Beeler was president of the Radiological Society of North America in 1975, speaker of the House of Delegates of the American College of Radiology for two years and served on its Board of Chancellors for six years.

Dr. Beeler resides in Indianapolis with his wife, Sally, and their three sons.

Screen Veterans for Hypertension

The Indianapolis VA Hospital is one of eight additional VA hospitals joining the specialized hypertension program. The VA expects to have 300,000 veterans in the program before long. The recent addition of eight brings the number of hospitals in the hypertension program to 32.

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Letters

to the editor

Dear *Journal*,

As some of the anatomical parts start wearing out it becomes necessary to make alterations in one's work schedule.

And so ended obstetrics for me.

A FAREWELL TO OBSTETRICS

I hate to see this time of my life go past and not return;

For as long as I live and practice my art I shall always yearn

For the pinkened face of the new-pregnant girl in my examining room,
And the soft, wiggly paunch that stretches the belt where the baby's life soon will bloom.

If I live to a hundred I'll always be thrilled by the new little creature that cries

When I help him or her from his watery home to the dry place above Mother's thighs;

And clean out his airway and smack him so sharp on his tiny but cute little rump;

Safely tie his cord, check him over so quick, and place him on Mom's shrunken hump.

There she can see what a fine child is he—or she

With a nose like her hubby's, a blonde—like her hair;

Makes no difference the size or the sex of the babe,

She's so glad to have him squirming up there.

And the wonderment I feel is part of why I'm glad I passed aviation by

And spent those years in school, maybe so I could deliver just one more baby!

But now it is past:

Watching little mothers grow around the middle,

And the hours of labor, and delivering one so little . . .

Now the fun and joy goes to a younger man

Who's only work is OB-GYN.

But I'll still think of pregnancy with pride and great love,

And if I had the chance, I'd do it all over again.

GENE S. PIERCE, M.D.
112 Professional Arts Bldg.
New Albany 47150

Market Commentary

The temporary reaction has apparently run its course and we believe clients are in for relatively smooth sailing the remainder of the year; continue to buy and hold stocks for the long term.

CURRENT TREND ANALYSIS

Divergence Again At The Turn

As has happened so often in recent months (the bottom in December of 1974; the top in July this year), divergence between the two averages has again provided a dependable tip-off to a turn in the market.

In late 1974, the industrial average fell to new lows, but the transportation average did not; this was the main reason for our December 16 Forecast entitled "A Bottom Area." Later events proved the bottom of the 1973-74 bear market had come 10 days before.

The exact reverse happened in June and July of this year. The industrial average rose to new highs, but the transportation average did not.

After the earlier 300 point advance in the Dow, an air of extreme optimism prevailed throughout the country, but we said on June 30 . . . "if the industrial average doesn't pull the transportation average up, the transportation average will pull the industrial average down . . . caution is recommended."

In the ensuing weeks, the industrial average failed to pull the transportation average up and as predicted, the transportation average then pulled the industrial average down some 80 points.

Finally, in recent weeks, the transportation average has fallen to new lows but the industrial average has stubbornly refused to follow suit. That was one of the main reasons we have felt recently that the reaction was near its low.

CURRENT STOCK SELECTIONS

Auto Stocks Attractive

While stocks are not as "cheap" as they were a couple of weeks ago, plenty of bargains are still available, in our opinion.

One of the most encouraging aspects of the recent market has been the excellent technical action of the automobile stocks. Years ago, "Engine Charlie" Wilson said "what is good for General Motors is good for the U.S. and vice versa." He was severely criticized by the press at the time, but no truer words were ever spoken.

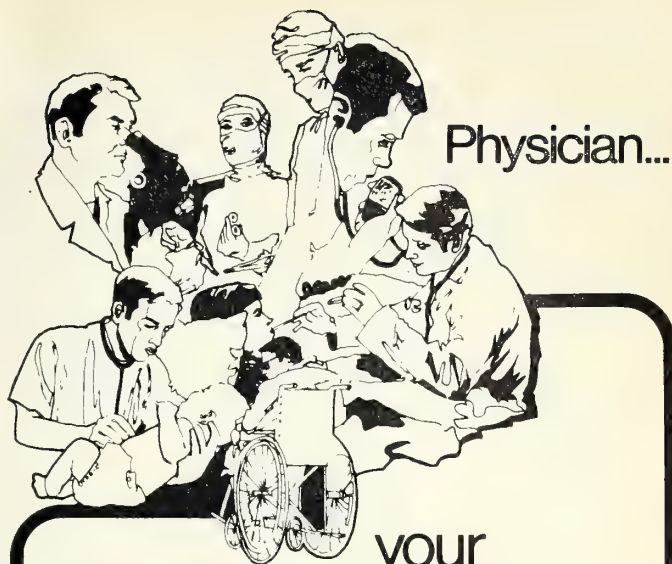
General Motors has rallied dramatically in recent weeks, but is still a good buy, in our opinion, as is Firestone, Texaco, Standard of Indiana, Monroe Auto and Echlin Mfg. Other good buying candidates abound also and include Walt Disney, which has risen 9% since being added here on August 18, but remains in a good buying range, and a new growth recommendation this week—McDonald's.

RCA remains very attractive, in our opinion, as does General Electric, Union Bancorp, Ocean Drilling, McGraw-Edison, Jewel Cos., Heinz, Georgia-Pacific, Taft Broadcasting, Bell & Howell and IBM.

Many of these have come off their recent bottoms, but we believe they have a long way to go before this bull market has run its course—probably some time in 1976.

CONCLUSIONS

From all indications, the recent reaction has run its course and stock prices should trend irregularly upward the remainder of the year. Continue to buy and hold stocks for the long term.—**Dow Theory Forecasts, Sept. 29, 1975. Reprinted with permission.**



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FUTURE MEETINGS, SEMINARS, COURSES

Annual Conference Scheduled By M. D. Anderson Hospital

The M.D. Anderson Hospital's 20th Annual Clinical Conference on "Neoplasms of the Skin and Malignant Melanoma" will be held at the Shamrock Hilton Hotel in Houston on Nov. 13 and 14. Write Steve Stuyck or call (713) 792-3030.

12th Annual IAFP-OB-GYN Meeting

The 12th Annual Postgraduate Course in Obstetrics and Gynecology will be presented Nov. 19 and 20 at Indianapolis under the sponsorship of the Department of Obstetrics and Gynecology of Indiana University, the Indiana Section of the American College of OB-GYN and the Indiana Academy of Family Physicians.

For further information and registration, telephone the latter's office at (317) 856-3757.

"A Day on the Liver" at Louisville

The 18th Annual Postgraduate Medical Seminar of the Norton Hospital, Louisville, will be held on Dec. 4 at Norton-Children's Hospitals. Indiana physicians are invited to attend. The program is approved for six prescribed credit hours by the American Academy of Family Physicians. The subject will be "A Day On The Liver." The seminar opens at 8:30 a.m. and will close at 4:45 p.m.

Surgeons to Meet in Hawaii in December

The United States Section of the International College of Surgeons will hold its Annual Meeting in Honolulu Dec. 5 to 9. Write the College at 1516 N. Lake Shore Drive, Chicago 60610 for complete information.

Five-day Course Scheduled at Chicago By American College of Physicians

The American College of Physicians will sponsor a five-day postgraduate course entitled "Fluid and Electrolyte Balance, Hypertension, and Renal Disease" Dec. 8 to 12 in Chicago at the Passavant Pavilion, Northwestern Memorial Hospital. For information and registration write to: Registrar, Postgraduate Courses, ACP, 4200 Pine St., Philadelphia 19104.

Rheumatic Disease: Management Options

The University of Kentucky Medical Center, Lexington, will present a postgraduate course titled "Rheumatic Disease: Management Options" Dec. 19 and 20. Registration fee: \$75.00. An added attraction is the U.K. Invitational Basketball Tournament to be held at Lexington on the 19th and 20th.

Further information may be obtained by writing Frank R. Lemon, M.D., Continuing Education, College of Medicine, University of Kentucky, Lexington 40506.

Neurological Society Announces Dates

The Indiana Neurological Society will meet at the Athenaeum, Indianapolis, at 7:00 p.m. on the following dates: November 7, 1975, February 6, March 12 and May 14, 1976.

Behavior Modification Technology Topic

A series of Intensive Behavior Modification Workshops has been scheduled by Behavior Modification Technology, Inc., as follows:

Philadelphia	Feb. 4-6
Chicago	Feb. 9-13 (5-day)
Atlanta	Mar. 3-6
New York	Mar. 31-Apr. 3
Cleveland	Apr. 21-24
Boston	May 5-8
Chicago	May 17-21 (5-day)

For information contact: BMT Inc., P.O. Box 597, Libertyville, Ill. 60048; (312) 367-0606.

Endoscopy Conference at Wisconsin

The Fourth Annual Endoscopy Conference by the Medical College of Wisconsin's department of medicine will be held Feb. 18 to 21, 1976. The fee for physicians is \$250. Write Anne T. Finnegan, 561 N. 15th St., Milwaukee 53233.

Pediatric Infectious Diseases Course Scheduled at Milwaukee Mar. 26-27

"Pediatric Infectious Diseases" is the subject of a symposium at the Milwaukee Children's Hospital, Mar. 26 and 27, 1976. Registration fee is \$100. For further information write Anne T. Finnegan, 561 N. 15th St., Milwaukee, Wis. 53233. The Medical College of Wisconsin sponsors the symposium and has applied for credit toward Category 1 of the AMA physicians' recognition award. The course is approved for eight hours of prescribed credit by the AAFP.

Major Dilemmas in Neonatal Pediatrics Symposium IV Set for Apr. 20-21, 1976

On Apr. 20-21, 1976, Methodist Hospital, Indianapolis, once again will host its annual Newborn Symposium, "Major Dilemmas in Neonatal Pediatrics." Among topics to be discussed are the adoptive neonate, dilemmas of maternal-infant interaction, phototherapy hazards, and long range follow-up of both the congenitally deformed child and the survivors of neonatal intensive care. Guest faculty will include Dr. T. Berry Brazelton (Harvard), Dr. Murray Feingold (Tufts), Dr. Gerald Odell and Dr. Henry Seidel (Johns Hopkins) and Dr. Philip Sunshine (Stanford).

For details write Richard S. Baum, M.D., The Newborn Center, Methodist Hospital, 1604 N. Capital Ave., Indianapolis 46202. Phone: (317) 924-8174.

New Orleans Assembly Starts March 29

The 38th Annual New Orleans Graduate Medical Assembly will meet at the Fairmont-Roosevelt Hotel Monday, Mar. 29 through Thursday, Apr. 1, 1976. The meeting is accredited by the American Academy of Family Physicians and by the American College of Emergency Physicians.



Natural balance doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

Found useful in the management of vertigo* associated with diseases affecting the vestibular system.

Can relieve nausea and vomiting often associated with vertigo*. Usual adult dosage for Antivert/25 for vertigo*: one tablet t.i.d. Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility. Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for seasickness, nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.


Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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New York, New York 10017

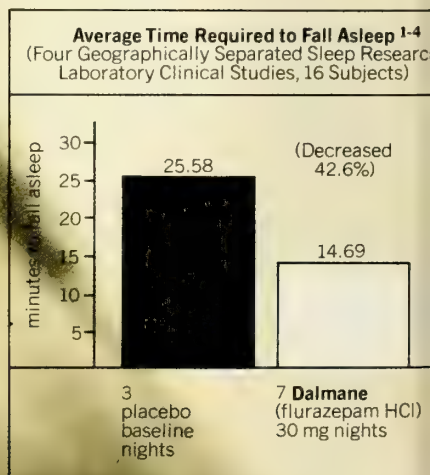
Antivert[®]/25
(meclizine HCl) 25 mg. Tablets
for vertigo*



How do you handle trouble falling asleep?

With Dalmane® (flurazepam HCl), results are highly predictable.

As demonstrated below, Dalmane induces sleep within 17 minutes, on average:¹⁻⁴



And for those with trouble
falling asleep or sleeping
long enough...

...sleep research laboratory
clinical studies prove: Dalmane
increases number of nighttime
awakenings and increases total
sleep time.⁵

Dalmane (flurazepam HCl)
relatively safe, seldom
causes morning "hang-over"

Dalmane is generally well
tolerated. The usual adult dose of
15 mg should initially be lowered to
5 mg for the elderly and
debilitated, to help preclude
oversedation, dizziness or ataxia.
Appraisal of possible risks is
suggested before prescribing.

REFERENCES:

Paracan I, Williams RL, Smith JR:
Sleep laboratory in the investigation
of sleep and sleep disturbances. Scientific
Exhibit at the 124th annual meeting of the
American Psychiatric Association,
Washington DC, May 3-7, 1971

Prosser JD Jr: A system for automati-
cally analyzing sleep. Scientific exhibit at
the 24th annual Clinical Convention of the
American Medical Association, Boston,
29-Dec 2, 1970; and at the 42nd
annual scientific meeting of the Aerospace
Medical Association, Houston, Apr 26-29,
1971

Logel GW: Data on file, Medical Depart-
ment, Hoffmann-La Roche Inc., Nutley NJ

Wolfe WC: Data on file, Medical
Department, Hoffmann-La Roche Inc.,
Nutley NJ

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Before prescribing Dalmane (flurazepam
HCl), please consult complete product
information, a summary of which follows:

Indications: Effective in all types of insomnia
characterized by difficulty in falling asleep,
frequent nocturnal awakenings and/or early
morning awakening; in patients with recurring
insomnia or poor sleeping habits; and in
acute or chronic medical situations requiring
restful sleep. Since insomnia is often transient
or intermittent, prolonged administration is
generally not necessary or recommended.

Contraindications: Known hypersensitivity
to flurazepam HCl.

Warnings: Caution patients about possible
combined effects with alcohol and other
CNS depressants. Caution against hazardous
occupations requiring complete mental alert-
ness (e.g., operating machinery, driving).
Use in women who are or may become preg-
nant only when potential benefits have been
weighed against possible hazards. Not
recommended for use in persons under 15
years of age. Though physical and psycho-
logical dependence have not been reported
on recommended doses, use caution in
administering to addiction-prone individuals
or those who might increase dosage.

Precautions: In elderly and debilitated, initial
dosage should be limited to 15 mg to preclude
oversedation, dizziness and/or ataxia. If
combined with other drugs having hypnotic
or CNS-depressant effects, consider potential
additive effects. Employ usual precautions
in patients who are severely depressed, or
with latent depression or suicidal tendencies.
Periodic blood counts and liver and kidney
function tests are advised during repeated
therapy. Observe usual precautions in
presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness,
lightheadedness, staggering, ataxia and
falling have occurred, particularly in elderly

or debilitated patients. Severe sedation,
lethargy, disorientation and coma, probably
indicative of drug intolerance or overdosage,
have been reported. Also reported were
headache, heartburn, upset stomach, nausea,
vomiting, diarrhea, constipation, GI pain,
nervousness, talkativeness, apprehension,
irritability, weakness, palpitations, chest
pains, body and joint pains and GU
complaints. There have also been rare
occurrences of leukopenia, granulocyto-
penia, sweating, flushes, difficulty in
focusing, blurred vision, burning eyes,
faintness, hypotension, shortness of breath,
pruritus, skin rash, dry mouth, bitter taste,
excessive salivation, anorexia, euphoria,
depression, slurred speech, confusion,
restlessness, hallucinations, and elevated
SGOT, SGPT, total and direct bilirubins
and alkaline phosphatase. Paradoxical
reactions, e.g., excitement, stimulation and
hyperactivity, have also been reported in
rare instances.

Dosage: Individualize for maximum beneficial
effect. *Adults:* 30 mg usual dosage; 15 mg
may suffice in some patients. *Elderly or
debilitated patients:* 15 mg initially until
response is determined.

Supplied: Capsules containing 15 mg or
30 mg flurazepam HCl.

You can
depend on the
efficacy of

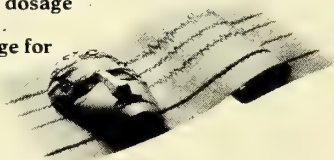
Dalmane[®]
(flurazepam HCl)

One 30-mg capsule h.s. — usual adult dosage

(15 mg may suffice in some patients).

One 15-mg capsule h.s. — initial dosage for
elderly or debilitated patients.

for insomnia



Objectively proved in the sleep research laboratory:

- sleep within 17 minutes, on average
- sleep with fewer nighttime awakenings
- sleep for 7 to 8 hours, on average,
with a single h.s. dose



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Nutley, New Jersey 07110

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association



The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. At some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

Opinion
&
Dialogue

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could reserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision has been made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



The Pain Phone

When a telephone prescription for pain relief is necessary or convenient, you can call in your order for Empirin Compound with Codeine in 45 of the 50 states† That includes No. 4, which provides a full grain of codeine for more intense, acute pain.

† The exceptions:
Alaska, Arizona, Maine,
Oregon, Rhode Island, and
the District of Columbia.

EMPIRIN COMPOUND & CODEINE

No. 4 codeine phosphate*
(64.8 mg) gr 1

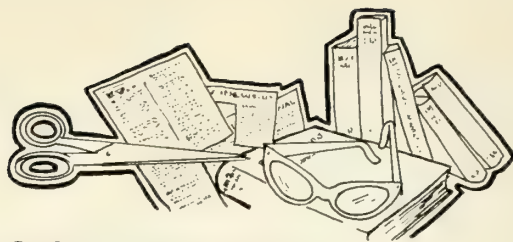
No. 3 codeine phosphate*
(32.4 mg) gr ½

Each tablet also contains aspirin
gr 3½, phenacetin gr 2½,
caffeine gr ½.

*Warning—may be habit-forming.



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Research Triangle Park
North Carolina 27709



BOOK REVIEWS

CLINICAL THERMOGRAPHY

J. D. Wallace and C. M. Cade, CRC Press, Cleveland, 1975;
\$12.95.

This 69-page monograph is a good introduction to the relatively new science of thermography. It discusses most of the problems of mammography incidental to developing the underlying basic science of thermal emission and its recording.

This should be an interesting review of relatively hard to find material for those wishing to bring themselves up to date on the clinical uses of photographic recordings of heat emission through the body. Areas of hyperemia and ischemia are sufficiently described to indicate the usefulness as a diagnostic tool. This sort of monograph, however, is insufficient to make one an expert and was apparently intended for a previously uninstructed general medical audience that had no previous contact with thermography.

It fulfills this indication quite well.

J. L. MORTON, M.D.
Indianapolis

THE POISONED PATIENT: THE ROLE OF THE LABORATORY

Ciba Foundation Symposium #26, new series, held in London in 1974; edited by Ruth Porter and Maeve O'Connor, Associated Scientific Publishers, Amsterdam and New York City, 325 pages in 18 chapters and an extensive general discussion.

This is an unexpectedly excellent symposium that starts out—rather prosaically—with an opening chapter outlining the well known fact that the poisoned patient needs prompt and generalized therapy to support life: never mind the exact causative agent. Then, the symposium settles down and starts on detailing the various well known poisons, from narcotics thru the “highs” of the amphetamines, analgesics thru the various “downers,” such as the phenothiazines, cannabis, etc.

Obviously, the laboratory can tell us a great deal in pinpointing the exact drug plus the exact amount present in the patient's body. Then, we are presented with drug assays by radioactive reagents, spectrophotometer systems, immunological methods for detecting digitoxin, morphine and their congeners; drug analysis in the overdosed patient, etc. And—finally—we are briefed in summary form as to the whole spectrum of just what the technicians have to offer the perspiring clinicians.

All in all, this volume is a must for the hospital and clinical laboratories; it should be scanned (at least now and then) by every pathologist and even the aspiring G.P.s. The paper and binding are good. There were no typographical errors.

ARNOLD LIEBERMAN, M.D.
New York City

MIKE ROY'S CROCK COOKERY

Mike Roy and Dan Fitzgerald, Dell Books, New York City, 1975; 124 pages; \$1.25.

Continued

Crock cookery is a modern day version of grandma's old Dutch oven! Since we do not have wood or coal burning stoves to permit all-day cooking, the new electric crock pot is a joy for the "working chef."

Before you buy a crock pot do read Mike Roy's book—he gives a marvelous description of all pots on the market and this should help you make the best purchase, helping you to know what to expect from your new pot.

Read the book if you have already purchased your pot. His recipes are tested and will help you adjust cooking time to your pot. Above all, heed his remark—"once started do not open the pot until cooking time is completed."

MILDRED R. RAMSEY
Indianapolis

ESSENTIALS OF GYNECOLOGIC AND OBSTETRIC ENDOCRINOLOGY

Habeeb Bacchus, M.D., Ph.D. University Park Press, Balti-

more, 1975; paper back; 232 pages with some diagrams and tables; \$12.50.

As the author confesses, in this volume we find the bare bones of the essential (and well known facts) anent the hormonal factors that regulate the female sex apparatus. In this day and age, this primer might be suitable for the sophomore medical student or the newly assigned intern just starting his OB and Gyn service.

The practicing M.D. should not be able to glean anything startling from a perusal of these pages. I do admit that—if he is in a hurry—the volume just might give him the needed answers: stat.

The printing, typing and paper are adequate. The few tables and diagrams might be just the answer when pressed for time. They surely are clear and elementary enough, descending almost to lay level. As the old saying goes, "you takes your choice," etc.

OB nurses and starting interns might find this just the item for them "to do their thing."

ARNOLD LIEBERMAN, M.D.
New York City

★

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The Woman's Auxiliary Reports to ISMA



Dear Doctors,

As I write this "Thanksgiving" article prior to the Indiana State Medical Association Convention, I'm assuming it is proper to congratulate Dr. Gilbert Wilhelmus for a job well done and to wish Dr. Vincent Santare the best for this coming year.

Recently Chloe Goldsmith (Mrs. David A.) and I have had the pleasure of visiting a number of county medical auxiliaries. We are delighted that many of your wives share their enthusiasm and dedication to enhance various community projects.

In addition to these endeavors, the National Auxiliary and the AMA sincerely hope that local auxiliaries will implement a one-time Bicentennial project. Since there is a paucity of literature in our public and college libraries por-

traying the role played by the AMA in its efforts to improve the quality of life in America, the AMA has published a three-volume set of books entitled "The Quality of Life." This set of books: Volume I—The Early Years, Volume II—The Middle Years, and Volume III — The Later Years, reports three national congresses sponsored by the AMA. This three-volume series reports to the public the many facets of life's continuum which every individual and public and private agency can do something about in improving the quality of life in America. Emphasized also is the necessity of an interdisciplinary approach with physicians joining forces with sociologists, educators, ministers, environmentalists, humanists and allied medical specialists to solve some of our major problems which adversely influence the health, well-being and quality of people's lives.

This three-volume series is marketed by the publisher at a price of \$31.50. For this special Auxiliary project, arrangements have been made for us to buy the entire series for \$10.00, plus \$1.00 handling and postage, from the AMA office, 535 North Dearborn Street, Chicago 60610, providing they are to be presented to your area public and college libraries. It is suggested that, in placing an order, the books be sent to a specific Auxiliary member who will assume the responsibility of personally presenting the books to the chief librarian or a professor of sociology, psychology or human relations in the colleges chosen to be recipients.

"Have a Happy Thanksgiving"

Sincerely,

A handwritten signature in cursive script that reads "Allie C. Reed".

Mrs. Edsel S. Reed
President
Indiana State Medical Auxiliary

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Each capsule contains 50 mg. of Dyrenium[®] (triamterene, SK&F) and 25 mg. of hydrochlorothiazide.

**TRIAMTERENE CONSERVES POTASSIUM
WHILE HYDROCHLOROTHIAZIDE
LOWERS BLOOD PRESSURE**

**FOR LONG-TERM CONTROL
OF HYPERTENSION***

Serum K⁺ and BUN should be checked periodically. (See Warnings Section.)



Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Warning

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has

been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and

BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Anti-hypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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AMA's Clinical Convention Flies to Hawaii !!

In addition to postgraduate courses, timely medical subjects will be offered each day in state-of-the-art lectures and symposia.

Advance Registration AMA Clinical Convention HONOLULU, HAWAII November 30-December 5

SCIENTIFIC COURSES

Monday-Wednesday, Dec. 1-3/7:30-9:00 AM (4½ hour, 3-day course: \$45)

1. Dermatology for Non-Dermatologists
2. Evaluation of the Unconscious Patient
3. Hyperlipidemia
4. Infectious Diseases in Children
5. Management of Adolescent Problems
6. Newer Antibiotics
7. Newer Concepts of Family Planning
8. Office Management of Sexual Difficulties
9. Peripheral Vascular Disease—Diagnosis and Treatment
10. Pulmonary Function Tests and Blood Gases

Monday-Wednesday, Dec. 1-3 (Numbers 1-10)

1st Choice # ____; 2nd Choice # ____; 3rd Choice # ____

Monday-Wednesday, Dec. 1-3/10:30 AM-Noon (4½ hour, 3-day course: \$45)

11. Acid-Base, Fluid and Electrolyte Balance
12. Advanced Electrocardiography
13. Critical Patients—Critical Decisions
14. Normal and Abnormal Uterine Bleeding
15. Office Management of Anorectal Disorders
16. Office Practice of Gynecology
17. Physicians' Marriages
18. Special Problems of Child Abuse
19. Surgical Lesions of the Intestines—Diagnosis and Treatment
20. Treatment of Common Pediatric Allergies

Monday-Wednesday, Dec. 1-3 (Numbers 11-20)

1st Choice # ____; 2nd Choice # ____; 3rd Choice # ____

Thursday-Friday, Dec. 4-5/7:30-10:30 AM (6 hours for total course; 3 hours on Thursday, 3 hours on Friday: \$60)

21. Acid-Base, Fluid and Electrolyte Balance (repeat)
22. Basic Electrocardiography
23. Birth Defects and Clinical Genetics
24. Dermatology for Non-Dermatologists (repeat)
25. Fetal Monitoring
26. Ophthalmoscopy for the Non-Ophthalmologist
27. Pediatric Cardiology
28. Pitfalls of Emergency Room X-Rays
29. Office Endocrinology
30. Immunology—1976
31. The Uterine Pap Smear

Thursday-Friday, Dec. 4-5 (Numbers 21-31)

1st Choice # ____; 2nd Choice # ____; 3rd Choice # ____

Offered Both Monday & Tuesday, Dec. 1 & 2/7:30 AM-Noon (4½-hour course: \$45)

32. Basic Life Support—Cardiopulmonary Resuscitation (Dec. 1)
33. Basic Life Support—Cardiopulmonary Resuscitation (Dec. 2)

Wednesday-Friday, Dec. 3-5/9:00 AM-Noon (9-hour course: \$90)

34. Advanced Life Support—Cardiopulmonary Resuscitation. (Prerequisite: Basic Life Support Course) (Dec. 3-5)

Courses of the AMA Committee on the Medical Aspects of Sports (Each a 3-hour course: \$30)

Monday, Dec. 1/7:30-9:00 AM & 10:30-Noon

35. The Physical Exam

Tuesday, Dec. 2/7:30-9:00 AM & 10:30-Noon

36. The Oriental Arts (Karate, Judo, Yoga)

Wednesday, Dec. 3/7:30-9:00 AM & 10:30-Noon

37. Emergency Care on the Field

Thursday, Dec. 4/7:30-10:30 AM

38. Wrestling
39. Aquatic Sports

Friday, Dec. 5/7:30-10:30 AM

40. Rehabilitation

Tuesday-Wednesday, Dec. 2-3/7:30-10:30 AM (6 hours for total course; 3 hours on Tuesday, 3 hours on Wednesday: \$60)

41. Writing for Scientific Journals

LUNCHEON ROUND TABLES

(Held in Hilton Hawaiian Village Long House Room, luncheon round tables are jointly sponsored by the AMA Auxiliary and AMA Council on Scientific Assembly. Cost: \$10.00 each.)

Tuesday, December 2 (12:15-1:45 PM) • Topic—Ancient Polynesian Medicine

Thursday, December 4 (12:15-1:45 PM) • Topic—Delhi Belly, Gypsy-Tummy, and Other Diseases of Travelers

General Registration

- | | |
|----------------------------------|--|
| ____ Non-member physicians: \$35 | ____ AMA members and their guests: no fee |
| ____ Guests of non-members: \$10 | ____ Medical students, interns and residents: no fee |
| ____ Foreign M.D.'s: no fee | |

My remittance of \$_____ is enclosed. Make check or money order payable to the American Medical Association. Payment must accompany registration.

Please print

Name _____
(Each physician must register in his own name)

Office Address _____

City/State/Zip _____

I am a member of the AMA through the following State Medical Association or government service _____

Office Phone No. _____

☐ Send travel information; or call toll-free to: (800) 621-1046, except in Alaska and Hawaii; in Illinois call (312) 782-3462

Return this form today to AMA's Dept. of Membership Statistics, 535 N. Dearborn St., Chicago, IL 60610

County, District News

Allen

Officers elected at the Fort Wayne-AlLEN County Medical Society meeting held May 20 at the Fort Wayne Country Club were: Drs. Charles H. Aust, president; W. Lloyd Bridges, president-elect; George W. Irmscher, secretary, and John Thomas, treasurer.

Bartholomew-Brown

Dr. James L. Stribling, Columbus, is the new president of the Bartholomew-Brown County Medical Society. Dr. Larry G. Willhite, Columbus, is serving as secretary.

Dearborn-Ohio

Dr. Rustico H. Dizon, Lawrenceburg, was elected president of the Dearborn-Ohio County Medical Society at its June meeting held at the Dearborn Country Club, Aurora. Dr. Guillermo Martinez was elected vice-president and Dr. Leslie M. Baker was reelected secretary-treasurer; both are of Aurora.

Decatur

The Decatur County Medical Society elected Dr. Robert P. Acher president, Alfredo Q. Paje, vice-president, and Dr. Arnold D. Ducanes, secretary-treasurer.

Fulton

Dr. James P. Schalliol, Rochester, has been elected president and Dr. Joseph D. Richardson, also of Rochester, secretary-treasurer of the Fulton County Medical Society.

Grant

Dr. James D. Reid, Marion, is the new president and Dr. Eugene Rifner, Van Buren, was reelected secretary of the Grant County Medical Society.

Huntington

Seventeen members of the Huntington County Medical Society attended its annual meeting held May 13 in the Huntington Elks Club.

Dr. Arthur N. Larson was elected president, Dr. Barbara J. Krueger, secretary, and Dr. Walter Kirsten, vice-president.

Montgomery

Dr. M. Keith Baird was elected president of the Montgomery County Medical Society at its annual meeting. Other officers elected were: Dr. Jose Peralta, vice-president, and Dr. Jack L. Foltz, secretary.

Randolph

Dr. Jerome M. Leahey, Union City, was elected president of the Randolph County Medical Society and Dr. C. R. Miranda, Winchester, was elected secretary-treasurer.

Tippecanoe

Newly elected officers of the Tippecanoe County Medical Society are: Dr. John Knote, president; Dr. Gilbert Gutwein, vice-president; Dr. David Evans, secretary, and Dr. Jacob Scheeres, treasurer. All are of Lafayette.

About Our Cover

Elaborate dinner preparations go on in the kitchen of the William Conner home at Conner Prairie Pioneer Settlement northeast of Indianapolis on Allisonville Road, six miles north of I-465 and four miles south of Noblesville. The restoration will celebrate its Traditional Christmas on Dec. 11-14 and 18-21 from 1 to 5 p.m., and the public is invited.

Conner Prairie Pioneer Settlement, Indiana's authentic restoration of the buildings and lifestyles that existed prior to 1840, will add yet another building to the tour—the office of a pioneer doctor typical of the pre-1840 era. Assistance in outfitting the physician's house and office is sought, in order that they may be as complete and authentic as other tour buildings. Donations are tax deductible.

The settlement is named for William Conner, a fur-trader, who came to what was to become Conner's Prairie in 1802, where he established a trading post and a family after his marriage to Mekinges, a Delaware Indian. In 1820, when by treaty the Indians ceded Central Indiana to the government, Conner's Indian wife and six children moved west with the Indians and his business changed from trading posts to mercantile establishments and mill operations. He married Elizabeth Chapman and his second family ultimately included 10 children.

Restoration of the farmstead was begun in 1934 when Mr. and Mrs. Eli Lilly acquired the property and restored and refurnished the house. Other buildings were brought in to recreate Conner's earlier life. The initial restoration was given to Earlham College in 1964. Expansion began in 1972.

The settlement will be closed from Nov. 9 to Dec. 11, when Christmas, 1840 style, will be occurring in the farmstead, the house (built in 1823), the blacksmith's house and shop, the general store and the schoolhouses.

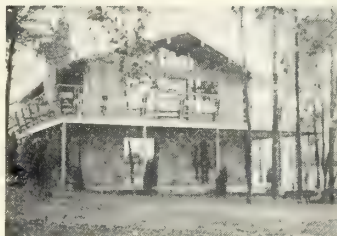
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Highland Springs offers choice wooded lake front building sites. There is a deluxe marina to put you on the reservoir and more than 35 miles of shoreline with excellent fishing. In essence, Highland Springs is a total escape from the hubub of the city. Yet it's only ½ hour away from Indianapolis and only 10 minutes from shopping in Castleton Square.



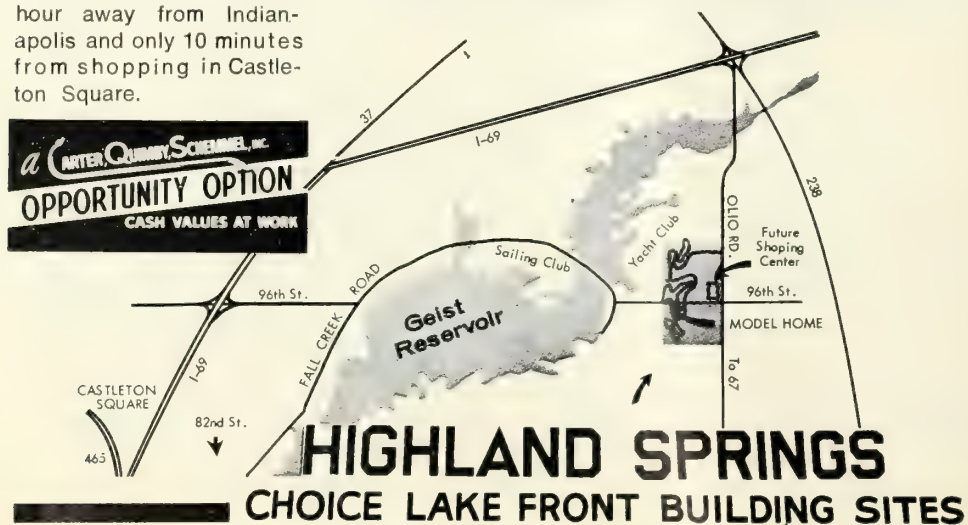
Homes on Highland Springs 3 Lakes are exclusively constructed by craftsmen selected by Opportunity Options Inc. This assures a graceful melding of optimum creature comfort with the natural beauty of the area.

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Association News

EXECUTIVE COMMITTEE

Aug. 6, 1975

The meeting was called to order at 6 p.m., at the Airport Holiday Inn by President Wilhelmus. Roll call showed the following present: William R. Clark, member; Vincent J. Santare, president-elect; Richard G. Ingram, chairman of the Board; Joe Dukes, immediate past president; Hugh K. Thatcher, Jr., treasurer; Frank B. Ramsey, editor, *The Journal*; James A. Waggner, executive secretary and Kenneth W. Bush, administrative assistant.

Guests: H. Pete Hudson, Indiana insurance commissioner; A. C. Offutt, M.D., and Wilbert McIntosh, M.D.

Inasmuch as Dr. Kerr had resigned as chairman of the Executive Committee, the first order of business was to elect a temporary chairman and, by secret ballot, Dr. Thatcher was elected temporary chairman.

The Committee entered into a discussion with Mr. Hudson concerning several matters dealing with the passage of H.B. 1460, the Professional Liability Bill, and also a discussion of the rates being charged Indiana physicians under the Risk Manager program. Mr. Hudson was candid in answering the many questions and suggested the executive secretary contact him on Fri., Aug. 15, at which time he thought he would have the answers to many of the questions asked by the committee. Following this discussion, Mr. Hudson excused himself from the meeting.

Dr. Offutt was called upon to make his report on the survey which he has completed for the ISMA. After a discussion of some of the findings, Dr. Offutt was asked to submit his abbreviated report to the members of the committee employed in overseeing this activity, namely, the president, president-elect, Dr. Dukes and Dr. James H. Gosman. Dr. Offutt then excused himself from the meeting.

Next Dr. McIntosh was called upon to discuss some of the organizational activities taking place in some of the Health Service Areas in Indiana and he suggested that ISMA should become more active in this. No action was taken on Dr. McIntosh's suggestions.

MINUTES OF THE MEETING HELD JUNE 7, 1975, were approved upon motion of Dr. Ingram and taken by consent.

THE MEMBERSHIP REPORT as of June 30, 1975, was reviewed and taken as a matter of information.

HEADQUARTERS OFFICE

The executive secretary submitted the letter of resignation of Dr. Donald Kerr as chairman and this will be referred to

the Board of Trustees, which is the group which will have to accept or reject his resignation.

EMPLOYEES' RETIREMENT PLAN.

The secretary gave a report on the employees' retirement plan and the revisions which must be made in the program by Jan. 1, 1976, and the increased cost to the Association for the continuance of the program under the new federal rules. After discussion, President Wilhelmus moved that this matter be left to the decision of the Board Committee on Fiscal Matters.

The secretary presented a proposal for sealcoating and repair of the parking lot and this was approved upon motion of Dr. Ingram and a second by Dr. Clark.

TEL-MED. The secretary then reported that the Regional Medical Program had granted an additional \$68,000 for the Tel-Med Program and made a recommendation about changing the equipment on incoming lines, which he estimated would create a savings over the next 12-month period in excess of \$21,000.

The secretary also informed the Committee that the St. Joseph County Medical Society was interested in installing a Tel Med unit and the funding would be done by a bank in South Bend but the doctors of St. Joseph County would still be listed as making the service available to the public. The secretary stated that under the present agreement, the ISMA has a statewide franchise on the system and it would be necessary for ISMA to approve this installation in St. Joseph County. The changeover in the system and the approval for St. Joseph County to install the system was approved upon motion of President Wilhelmus and a second by Dr. Clark.

A letter was received from a physician proposing changes to be made in their local hospital and other matters were discussed and it was felt that the request for legal opinion should be a formal request initiated by a county society and not an individual physician. It was also noted that the physician should be informed that perhaps the Hospital Facility Licensing Council might be employed to assist them in their problem and that some of the other matters contained in the letter would not have an impact on the total physicians in the state and therefore should be discussed with an attorney of their choice in their own community.

Letter from another hospital staff raising certain questions concerning Utilization Review was discussed. The secretary was instructed to send the president of the staff the report of the AMA suit and the findings of the judge which at the point in time prohibited HEW from enforcing this regulation.

The letter from William Paynter, M.D., commissioner, Indiana State

Board of Health which had been deferred until this meeting was again discussed and, upon motion of Dr. Ingram and a second by Dr. Santare, the secretary was advised to inform Dr. Paynter that ISMA would cooperate with AMA in setting up a program called ASTHO, which is a training program for doctors as medical directors in skilled nursing facilities, providing there is no financial obligation on the part of ISMA.

A letter suggesting ISMA nominate Leo J. McCarthy, M.D., of Indianapolis as a candidate for membership on the AMA Transfusion Committee was approved on motion of President Wilhelmus and taken by consent.

A letter requesting a contribution from ISMA for the Indiana Conference on Social Welfare, Inc., was reviewed and no contribution to be made upon motion of Dr. Ingram and taken by consent.

A letter from a physician for a refund of his \$50 which he had loaned to the Association for the building of the headquarters office was reviewed. The physician has lost his certificate but was eligible for a refund, inasmuch as a copy of the certificate was contained in the files of the headquarters office. Refund was authorized upon motion of President Wilhelmus and a second by Dr. Santare.

The discussion of HEALTH SERVICE AREAS, the consortium which has been set up by organizations, not including Indiana State Medical Association, was reviewed, and this is to be referred to the Board with the suggestion that the Board authorize the trustee from Indiana to exert efforts to get the AMA to sue the government to oppose the formation of HSAs.

Copies of letters addressed to malpractice carriers were reviewed and, upon motion of Dr. Ingram, the secretary is instructed to write a letter to one of the physicians and explain to him the Association is making a sincere effort to resolve some of these problems that are cropping up since the passage of H.B. 1460, informing him we have had several meetings with the Insurance Commissioner and we hope to have answers to some of his questions by Aug. 15.

The Committee reviewed a letter received from Harlan of Texas indicating the company is still interested in working out a program for Indiana in the malpractice field. By consent, the information is to be turned over to the Commission on Medical Economics and Insurance.

The secretary made a report, following a telephone conference with CNA. The secretary was authorized to inform the Commission on Medical Economics and Insurance that they should meet with the officials of CNA in an effort to convince them that Indiana is a viable market for them.

Copies of letters addressed to a state senator by an insurance carrier were

reviewed for information of the committee.

Action by the Blue Shield regarding INDIVIDUAL PRACTICE ASSOCIATION matter was taken as a matter of information, inasmuch as this will be discussed by the Board on Aug. 10.

The secretary presented several letters about fees paid on the CHAMPUS program and he reported he was in a series of negotiations with the federal government at this time in an effort to resolve the problem.

The committee received a note from the Ohio State Medical Association announcing the fact it would nominate John H. Budd, M.D., for the office of president-elect of the American Medical Association.

Request for a contribution from the American Association of Medical Assistants, Inc., was taken as a matter of information.

Report on sale of exhibit space for the annual meeting was given by the secretary.

NEW BUSINESS

The secretary read a letter from the Texas Medical Association requesting copies of the constitutional opinion on H.B. 1460. This matter is to be referred to the Board of Trustees.

The secretary reported he had received a letter addressed to Blue Cross-Blue Shield complaining about the failure of the Blues to accept a claim on a uniform claim form. Discussion was pointed out that the Blues had stated before the Board that they would accept claims on this form and the secretary is instructed to send a copy of the letter to President Wilhelmus.

President Wilhelmus brought up a matter concerning what the doctors in a community feared was an informer in a hospital who was tipping off lawyers as to possible malpractice cases that might have been seen in the hospital emergency room. Following a discussion of this, the President will consult with the physicians in the community regarding the situation.

President Wilhelmus also brought up the fact that the Welfare Department had requested that a committee be established to review questionable claims, particularly one by an Indiana physician who is not a member of his county or state association, and the committee concurred with President Wilhelmus that inasmuch as this man was not a member we could do nothing about it and he is to recommend to the Welfare Department director that he should refer this matter to the Indiana Medical Licensing Board.

President Wilhelmus also reported on a discussion he had with Mrs. Allie Reed, president of the Auxiliary, regarding finances and the financial problems of the Auxiliary. He proposed that the

Association might ask for a \$1.00 dues increase to be given to the Auxiliary. This was referred to the Board of Trustees.

MEDICAL DEFENSE

The secretary presented a claim from an Indiana physician for payment of an attorney fee in a malpractice case. The secretary is to inform the physician that the House of Delegates in October 1974 changed the conditions of paying for medical defense and, therefore, we regretted we could not assist him in this repayment and also call his attention to the fact that his application for defense was not received in the headquarters office until July 23, 1975, and apparently the case had been in litigation since 1972.

FUTURE MEETINGS

American Medico-Legal Institute Symposium, Las Vegas, Aug. 11-14. No representative will be sent.

Department of Health, Education, and Welfare Emergency Medical Services Systems, Chicago, Sept. 9 and 10. No representative will be sent.

AMA's Fifteenth National Conference on Physicians, Schools and Community, Chicago, Nov. 20 and 21. No representative will be sent.

Workshop for National Joint Practice Commission, Chicago, Nov. 2-4. No representative will be sent.

There being no further business, the meeting adjourned at 11 p.m. with the next date for the meeting of the Committee set for 3 p.m., Sat., Sept. 20, 1975, in the headquarters building.

BOARD OF TRUSTEES

Sunday, Aug. 10, 1975

Dr. Richard Ingram, chairman of the Board, called the meeting to order at 9:10 a.m. in the headquarters office.

ROLL CALL

Dist.

Trustee

1	Bernard B. Rosenblatt	Present
2	Paul W. Holtzman	Present
3	Eli Goodman	Present
4	Howard C. Jackson	Present
5	Cleon M. Schauwecker	Present
6	Paul M. Inlow	Absent
7	John O. Butler	Absent
8	Joseph F. Ferrara	Present
9	Richard G. Ingram	Present
10	William M. Sholty	Present
11	Martin J. O'Neill	Present
12	James A. Harshman	Present
13	Alvin J. Haley	Present
	G. Beach Gattman	Present

Dist.

Alternate

1	E. DeVerre Gourieux	Absent
2	Edgar R. Cantwell	Absent
3	Thomas A. Neathamer	Absent
4	William F. Blaisdell	Present

5	William G. Bannon	Present
6	Glen Ward Lee	Present
7	Donald C. McCallum	Absent
7	John G. Pantzer	Present
8	Jack L. Alexander	Absent
9	Max N. Hoffman	Absent
10	Leonard W. Neal	Present
11	Lloyd L. Hill	Absent
12	Franklin A. Bryan	Present
13	Donald S. Chamberlain	Present

Officers/Executive Committee

Gilbert M. Wilhelmus	Present
Vincent J. Santare	Present
Hugh K. Thatcher, Jr.	Present
Arvine G. Popplewell	Absent
Frank B. Ramsey	Present
Joe Dukes	Present
John W. Beeler	Present
William R. Cast	Present
William R. Clark	Present

AMA Delegates/Alternates

Patrick J.V. Corcoran	Present
Lowell H. Steen	Present
James A. Harshman	Absent
John O. Butler	Absent
Malcolm O. Scamahorn	Present
Thomas C. Tyrrell	Absent
Peter R. Petrich	Absent
George T. Lukemeyer	Absent
Ross L. Egger	Absent
Everett E. Bickers	Absent

Guests

Wally Bruner	Present
Peter E. Gutierrez	Present
Tim Spencer	Present

Staff

Robert J. Amick	Present
Kenneth W. Bush	Present
Howard Grindstaff	Present
Bob Sullivan	Present
James Waggener	Present

RESIGNATION OF EXECUTIVE COMMITTEE CHAIRMAN

Dr. Donald Kerr submitted his resignation as chairman of the Executive Committee. It was moved that the Board of Trustees accept the resignation. The motion was seconded, put to a vote and carried. The Board also passed a motion commending Dr. Kerr for his many years of loyal service and also moved that he and Mrs. Kerr be invited to the Trustees' Dinner at the forthcoming state convention. The Board then elected Dr. Eli Goodman to fill the vacated position on the Executive Committee until the October 1975 convention.

RESIGNATION OF AMA DELEGATE DR. LOWELL H. STEEN

Dr. Steen submitted his letter of resignation to President Wilhelmus. The Board was advised by Dr. Harshman that Dr. Steen's alternate delegate would sit in that chair as delegate until the ISMA convention in October when the position, by election, would be filled by the House of Delegates.

MINUTES OF THE JUNE 8, 1975, BOARD MEETING

Motion was made and seconded that the minutes be approved as circulated. The motion was put to a vote and carried.

REQUEST FROM SOUTHWESTERN MEDICAL REVIEW ORGANIZATION

The Southwestern Medical Review Organization at the June 8, 1975, meeting of the Board had requested a letter of endorsement from the Indiana State Medical Association and the motion to disapprove the request was tabled until this meeting. The Board, following additional consideration of the request, voted not to endorse the Southwestern Medical Review Organization.

STUDENT LOAN FUND

Motion was made and seconded that the loan recipients shall be resident students attending the I.U. School of Medicine and Indiana residents attending approved medical schools elsewhere in the United States. Following discussion, the Board tabled this motion until a later time. The Board then received a motion which was seconded and passed that the ISMA accept the guidelines of the AMA-ERF in granting loan funds. An additional motion was also passed by the Board incorporating the following into the loan program; that the mandatory co-signer not be dropped, the interest be based on the prime interest rate, the Indiana National Bank guaranteed reserve not be increased to 10% but remain at 8%, and that the letter from the Indiana National Bank with these changes be accepted as written.

REPORT OF THE PRESIDENT

President Wilhelmus gave a report of his activities since the last Board meeting, pointing out that he had been on both coasts discussing Indiana's Patient Compensation Act before medical organizations. President Wilhelmus also discussed the need of the Woman's Auxiliary for additional funds to carry out increasing numbers of projects. Dr. Wilhelmus said that his discussions with the Auxiliary officers had resulted in a resolution to be introduced into the House of Delegates which would ask for a \$1 dues increase per member of the ISMA to be annually earmarked for the Auxiliary. This amount would be in lieu of the present \$1000 annual grant to the Auxiliary. The Board adopted a motion to support the increase for the Auxiliary.

President Wilhelmus also reported on requests from other state medical societies for copies of the ISMA legal opinions on the constitutionality of H.B. 1460, the Patients' Compensation Act. The Board approved a motion to charge a fee for supplying these opinions to other medical organizations to offset some of the costs to the ISMA in obtaining these opinions.

REPORT OF THE PRESIDENT-ELECT

Dr. Santare reported on his efforts to get additional funding for Tel-Med from United Ways throughout Indiana and the revision of the commission and committee structure of ISMA. Concerning these revisions, the Board adopted a motion which recommends to the Commission on Constitution and Bylaws that the Commission on Medical Economics and Insurance be placed under the proposed Commission on Medical Service.

The Board also adopted a motion which stated that the president shall appoint the members of the reference committees after due consultation with the speaker of the House. This recommendation was referred to the Commission on Constitution and Bylaws.

The Board approved Dr. Santare's continued participation, on behalf of ISMA, with Health Services Management, an organization currently undertaking a census of physicians in Indiana.

REPORT OF THE EDITOR OF THE JOURNAL

Dr. Frank Ramsey reported that the editorial board of THE JOURNAL would give consideration to changes in THE JOURNAL and that their recommendations would be reported to the Board of Trustees following the meeting at French Lick in October.

INDIVIDUAL PRACTICE ASSOCIATIONS

Following lengthy discussion of this subject, the Board passed two motions. One motion stated that assignment of surveillance of Individual Practice Associations be given to the Blue Cross and Blue Shield Liaison Committees of the Board of Trustees and that these committees keep the Board informed on developments in this area. Drs. Holtzman and Harshman were named co-chairmen of the committee. The second motion which was passed asked that the committee consult with Blue Shield members as quickly as possible and that the committee be authorized, if they felt it necessary, to keep the Board informed on developments through a telephone conference.

REPORT OF THE TREASURER

Acceptance of the Treasurer's Report was moved, seconded and passed.

REPORT OF DISTRICT TRUSTEES

Second District—The 1976 meeting will be held in Washington, Indiana.

Third District—The 1975 meeting will be held Sept. 13 and 14 at the Marriott in Clarksville, Indiana.

Fourth District—The 1976 meeting will be held in Greensburg, Decatur County. No date has yet been set.

Fifth District—Dr. Schauwecker asked for information concerning election of a Blue Shield representative from his dis-

trict. He pointed out that it was tentative, but it appeared that a replacement of their representative may be necessary.

Seventh District—The 1975 meeting of the district has not yet been called. It was pointed out that the executive secretary of ISMA has the authority to call the meeting and probably would have to do it. The 1976 meeting will be held in Franklin. No date has been set.

Ninth District—The meeting will be held June 10, with golf at the Purdue South Course and the meeting at the Hilton.

Tenth District—The 1975 meeting will be held Sept. 24 at the Valparaiso Country Club.

Eleventh District—Meeting will be held Sept. 17 at the Delphi Country Club.

Twelfth District—Meeting will be held September 11 at the Ramada Inn, Fort Wayne, with golf at the Elks Club course.

Thirteenth District—Meeting will be held Sept. 10 at the South Bend Country Club. The District Society is importing a chef from New Orleans to prepare the dinner and the Chicago Gaslight Club will provide the entertainment.

REQUEST FROM THIRTEENTH DISTRICT FOR MAILING LIST

Motion was made and seconded that the ISMA mailing list for the thirteenth district be provided to the District Medical Society.

LIAISON COMMITTEE WITH BLUE CROSS

The Board discussed the matter of Blue Cross and Blue Shield limiting mailings of their Executive Committee and Board minutes. These have been mailed in the past but recently the names of the Liaison Committee had been eliminated from the list. President Wilhelmus said he would write to the Blue Cross president requesting that the ISMA be put on the distribution list to receive the minutes of the Blue Cross Executive Committee. Included also will be a request for the Blue Shield Executive Committee and Board minutes.

NATIONAL HEALTH INSURANCE COMMITTEE

President Wilhelmus advised the Board that he is currently receiving continuing information from the AMA on national health insurance.

REPORT OF THE AMA DELEGATION

Full report was made to the Board on the activities of the ISMA delegation and actions of the AMA House of Delegates. Expression of congratulation was given the delegation for their activity with the statement that "their conduct of our interests at this AMA meeting has to be rated as having been superior." The Board, by consent, accepted the commendation of the delegation.

REPORT OF THE EXECUTIVE COMMITTEE

Employment Retirement Plan—This matter was referred back to the Committee on Economic and Fiscal Matters for decision and recommendation.

Tel-Med—Motion was made to permit St. Joseph County to utilize Tel-Med under the sponsorship of the St. Joseph Bank and Trust Company. Letter to the Board had expressed the point that the Board of Trustees of the St. Joseph County Medical Society was very much in favor of the bank's proposal. The ISMA Board adopted the motion.

Medical Director Training—Request was made that the ISMA co-sponsor with the Indiana State Board of Health an AMA training program for medical directors of skilled nursing homes. The Executive Committee adopted the concept as long as there was no financial aid required of the ISMA. The Board passed a motion that the recommendation be adopted.

Plaque for Kenneth O. Neumann, M.D.—Board considered the matter of a plaque in memory of Dr. Neumann. Motion was made, seconded and carried that the plaque be imprinted on a metal plate and framed appropriately, rather than hand-lettered.

Exhibit Space—It was reported to the Board that there are 47 spaces available with 11 spaces sold and two tentative spaces requested.

Health Service Areas—The recommendation of the Executive Committee to the Board on the subject of Health Service Areas, the legislation involved, was that the ISMA recommend to the AMA Board of Trustees that they do in fact seek an injunction preventing implementation of this law. It was pointed out to the Board that the AMA House of Delegates had made a rather strong statement to the AMA Board pertaining to the subject. It was suggested to the ISMA Board that they concur in the action of the AMA House of Delegates and that the ISMA implore the AMA Board to take any action necessary, including legal action, to prevent the implementation of the law. It was moved by the Board, seconded and adopted, that a letter be written to the AMA supporting that position.

RADIO AND TELEVISION PROGRAMS

The Board heard two reports and demonstrations on possible radio and television programs which could be utilized for medical public relations in Indiana. The Board moved that the presentation by Mr. Bruner be endorsed by the ISMA contingent upon the sanction of the county medical society from which the program would be transmitted. The Board also moved that a program presented by Mr. Spencer not be considered.

JOINT COMMISSION ON ACCREDITATION

Dr. Schauwecker reported to the Board on the current activities of his committee to assist medical staffs of hospitals with their Joint Commission on Accreditation surveys. He reported that he had been in contact with the officials of the Joint Commission in Chicago and had worked out a mutually satisfactory program of cooperation with the Commission to assist hospital medical staffs in Indiana. He presented the plan to the Board which moved approval and that the committee's efforts be continued.

HIGH BLOOD PRESSURE PAMPHLET

The Commission on Public Information requested that the name of the Indiana State Medical Association be allowed to be placed on a pamphlet produced by Blue Shield and Blue Cross concerning high blood pressure. The Board accepted the recommendation of the Commission.

IMMUNIZATION PROGRAM PROPOSAL

The Commission on Public Health presented a program to the Board concerning immunization of children. The Board took the following actions: (1) Rejected a proposal in the plan asking for a \$7,600 expenditure for printing immunization record cards, (2) Approved utilizing spot announcements for radio and television concerning the need for immunizations, (3) Approved sending general news releases giving specific information about immunization levels in

the state, (4) Approved urging PTAs and PTOs to help publicize the necessity for immunization of preschool children and those already in school, (5) Tabled for an indefinite period of time a recommendation that legislation be sought making it mandatory that children be immunized before entering school.

PROFESSIONAL LIABILITY

The Board discussed the development of an Association-sponsored program. The Board adopted a motion to appoint an ad hoc committee to continue seeking information for possible solutions to the professional liability problems. Dr. Ferrara was named chairman and Drs. Harshman and Santare will serve as members.

COMMITTEE ON ECONOMIC AND FISCAL MATTERS

The Board heard a report from the Committee on Economic and Fiscal Matters. The Committee recommended to the Board that the two special \$10 assessments for a two-year period, passed by the House of Delegates, be continued and that a \$10 dues increase also be proposed to the House of Delegates. The Board accepted a motion that the Committee's report be adopted and that such a recommendation be made to the House.

SPORTS AND MEDICINE PROGRAM

The chairman reported that representatives of the Committee on Sports and Medicine had been invited twice to appear before the Board to explain the program, but no one had appeared. The program has to do with developing qualified athletic trainers for Indiana high schools.

NBC TELEVISION SERIES

The Board heard a brief report on a new television program produced by NBC to be aired weekly which reflects negatively upon the medical profession. The Board was advised that the AMA had asked to preview the shows and scripts and had been refused.

ADJOURNMENT

The Board recessed at 4:45 p.m. to meet in executive session.

Copies of the 1975 Roster and Yearbook are available at the office of THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208. Price: Yearbook (June issue): \$10.00; Roster: \$5.00 each. Please send check with order.

COMMERCIAL ANNOUNCEMENTS

FOR RENT — Luxuriously furnished two-bedroom beach condominium on Marco Island, southwestern Florida, overlooking Gulf and island. Weekly or monthly. Swimming, fishing, boating, golf and tennis. Call 317-291-7655.

DOCTORS—THE NEXT MOVE IS YOURS . . . Midwest Medical, Inc. will provide you with more information about each opportunity than you have ever imagined possible. For the first time you can visually preview the Community and Medical Facilities of over 80 opportunities in the Upper Midwest, at ONE location. Saves you time, expense, and frustration. For a thorough appraisal of all factors involved, please accept our invitation to call. For discreet and confidential assistance contact M. A. Cornwall, M.D., MMI's Medical Director, or write: Midwest Medical, Inc., Lakeland, Minnesota 55043, 612/436-5161. Locum Tenens opportunities always available.

INTERNISTS bd. cert. or elig. needed to help develop ICU, pulmonary care, step down, diagnostic and treatment units in newly modernized, 210-bed Med. Unit. Strong in intensive care and rehabilitation. Full PT, CT and activity therapy clinics under direction of a physiatrist are avail. to enhance treatment. Med. Svc. part of a larger Med. Center having excellent ambulatory care, psychiatric and geriatric services. CAP approved lab. OSMA approved Cont. Med. Ed. Prog. for AMA Phy. Recognition Award. Hosp. located in southern Ohio natural recreation and scenic area. 9-hole golf course and swimming pool on campus. Many cultural and educational advantages. Within commuting dist. of 2- and 4-year colleges and universities. 1 hr DT from Columbus. License in any state accepted. Salary open and competitive. Financial assistance in moving. Nondiscrim. in employ. Write or call collect Chief of Staff, VA Hospital, Chillicothe, Ohio, (614) 773-1141.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be consid-

ered for display type advertising.

Charges for commercial announcements are:

15¢ for each word

\$3.00 minimum

Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month PRECEDING month of issue.

WE NEED A DOCTOR

Fowler, Indiana

Location: Fowler, Indiana is 28 miles northwest of Lafayette. County seat of Benton County. Fowler population 2,900, County population 12,000.

Hospital facilities: Home and St. Elizabeth Hospitals in Lafayette, 30 minutes away; one 23 bed nursing home and a clinic housing one doctor and one dentist.

Possible group practice available or purchase of vacant private clinic. If interested, call John Barce, 317-884-0364 or 317-884-0544. Write P.O. Box 566, Fowler, Indiana 47944.

INTERNIST to assume 36-year practice for purchase of office building and contents; two apartments; lab.; EKG; X-Ray; northern Indiana; city population 40,000; retiring Jan. 30, 1976. Telephone 219-233-2332.

PHYSICIANS WANTED

SPECIALISTS AND GENERALISTS working together to make the Hartford area a better place to live and practice medicine. Thirteen physicians presently serve the area in two clinics and also solo practice—there is a need for more physicians to serve this fast growing area—specifically in Family Practice and Internal Medicine. A new Hospital building has been completed and will provide the best facilities possible. The service area population is over 30,000, while Hartford is a community of 7,000 and part of the metropolitan Milwaukee Planning Area, less than 30 minutes away from major cultural, educational and social resources. Hartford and its outlying communities offer more of a rural community flavor with proximity to lakes, ski hills and other recreational advantages. This invitation to Hartford Wisconsin is the cooperative effort of the physicians, clinics, hospital and interested community leaders. Contact the Hartford Community Physician Research Committee by letter or phone, through N. K. Reynolds, at Hartford Memorial Hospital, 1032 E. Sumner, Hartford, Wisconsin 53027 (414) 673-2300.

Are You Moving?

If you're moving soon, please let us know at least six weeks before you move.

Send change of address to
The Journal, ISMA
3935 N. Meridian St.
Indianapolis, IN 46208

Name _____

Address _____

City _____ State _____ Zip _____

County _____

IMPORTANT — Attach mailing label from your last Journal here.

Indiana Medical Foundation, Inc.

Established by the Indiana State Medical Association for educational and scientific purposes, including an endowment fund for publication of **The Journal**.

Contributions made to the Foundation are deductible by donors in accordance with the Internal Revenue Code.

Bequests, legacies, devises, transfers or gifts to the Foundation are deductible for Federal estate and gift tax purposes.

The Foundation is an ideal recipient of gifts made in memory of deceased friends and relatives. A special Memorial Book is maintained to record such gifts. Special memorial funds may be established within the Foundation to honor individuals.

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In accepting advertising for publication, **THE JOURNAL** has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make any comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertiser only. Neither sanction nor endorsement of such is warranted, stated or implied by the association.

LIBRIUM[®]

(chlordiazepoxide HCl)

FOR ALL THE RIGHT REASONS.

- prompt and specific action
- documented benefit-to-risk ratio
- three dosage strengths to meet most therapeutic needs



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental

alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium[®] (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose[®] packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs[®] (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

LIBRIUM[®]

chlordiazepoxide HCl/Roche
5 mg, 10 mg, 25 mg capsules

Please see following page.

LIBRIUM[®] **(chlordiazepoxide HCl)**

FOR ALL THE RIGHT REASONS.

Yesterday's decision to use Librium for a clinically anxious patient was based on several good reasons. Safety. Effectiveness. Versatility. And the reasons you chose it yesterday are as valid today.

Librium has accumulated an unsurpassed clinical record. A record validated in several thousand papers published both here and abroad.

Librium, when used in proper dosage, rarely interferes with a patient's mental acuity or ability to perform. However, as with all CNS-acting agents, good medical practice suggests that patients be cautioned against hazardous activities requiring complete mental alertness.

Librium has an established safety record and a documented benefit-to-risk ratio. And Librium is used concomitantly with such drugs as cardiac glycosides, diuretics, anticholinergics and antacids.

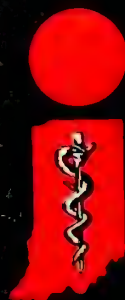
So when you consider antianxiety therapy, consider Librium. It's a good choice. For today. And tomorrow.



PROVEN ADJUNCT FOR CLINICAL ANXIETY

LIBRIUM[®]
chlordiazepoxide HCl/Roche

Please see preceding page for summary of product information



The JOURNAL

OF THE INDIANA STATE
MEDICAL ASSOCIATION

December 1975 • Vol. 68 • No. 12 • Indianapolis

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DEC 30 1975

Univ. of Calif., San Francisco
SAN FRANCISCO, CA 94143

Season's Greetings.

Both often



● Predominant psychoneurotic anxiety

● Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor

neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

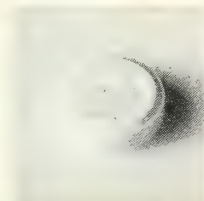
respond to one


According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent

in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium[®]
(diazepam) 
2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

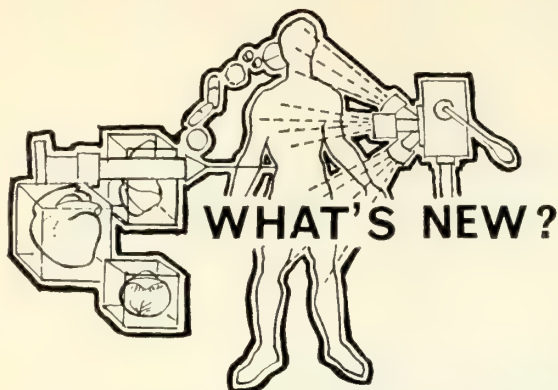
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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Dow Pharmaceuticals is introducing NOVAFED® Capsules (pseudoephedrine Hcl controlled release) with prompt onset of action and 12-hour duration for the relief of nasal congestion. The medication is dispensed in 120 mg capsules.

* * *

Boehringer Ingelheim announce a new anti-emetic, Torecan® (thiethylperazine), a phenothiazine. A randomized double-blind clinical study involving Torecan and two other anti-emetics showed better effect and longer action for Torecan.

* * *

American Optical introduces a new CardioResuscitation System called the Pulsar™4 System. It combines a scope, recorder and defibrillator, all in one case. The case is seamless and high-impact, water- and weather-resistant.

* * *

Parke-Davis announces Triazure for the treatment of severe, recalcitrant psoriasis. Triazure is the brand name for azaribine which has been under clinical study since 1963. It is taken orally. In nine double-blind controlled studies, almost 70% of the patients showed good-to-excellent clinical improvement.

* * *

Herculite Protective Fabrics announces 'LECTROLITE™ fabrics which are electrically conductive. The fabrics also possess lasting antibacterial and flame resistant properties. They satisfy O.R. safety standards and meet the conductivity requirements of the National Fire Prevention Association. Also have many uses in the hospital outside the operating room.

* * *

Miles Laboratories announces CATALINKS™, a nylon tube-immobilized enzyme, in which the enzyme is covalently linked to the inner surface of the tube. The enzyme reacts to samples passing through the tube, but is not consumed or washed away. CATALINKS are reusable reagents for use in automated analysis machines. A single CATALINKS tube has been used for over 10,000 tests at the rate of 60 tests per hour.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

KAY CIEL® ELIXIR

(potassium chloride) 10%

DESCRIPTION: Each 15 ml. (one tablespoonful) contains potassium chloride 1.5 Gms., supplying 20 mEq. of elemental potassium, and 20 mEq. of chloride, in a cherry-flavored, palatable base; alcohol 4%. Contains no sugar.

INDICATIONS: Treatment of potassium deficiency occurring especially during thiazide diuretic or corticosteroid therapy, digitalis intoxication, low dietary intake of potassium, or as a result of excessive vomiting and diarrhea. Other causes of hypokalemia are fistulae, laxative abuse, villous adenoma, familial periodic paralysis, hyperthyroid periodic paralysis, insulinoma, primary aldosteronism or secondary aldosteronism, Cushing's Disease, renal potassium wasting conditions such as potassium wasting nephritis, and alkalosis.

CONTRAINDICATIONS: Impaired renal function, untreated Addison's Disease, dehydration, heat cramps and hyperkalemia.

PRECAUTIONS: Potassium chloride should be administered with caution and adjusted to the requirements of the individual patient, since the amount of deficiency and corresponding daily dose is often not known. Excessive or even therapeutic doses may result in potassium intoxication. The patient should be checked frequently and periodic ECG and/or plasma potassium levels made. High plasma concentrations of potassium ion may cause cardiac depression, arrhythmias or arrest. Use with caution in patients with cardiac disease. In hypokalemic states, attention should be directed toward the correction of the frequently associated hypochloremic alkalosis.

ADVERSE REACTIONS: Vomiting, nausea, abdominal discomfort and diarrhea may occur. Symptoms and signs of potassium intoxication include listlessness, mental confusion, paresthesia of the extremities, weakness of the legs, flaccid paralysis, fall in blood pressure, cardiac arrhythmias, and heart block. When hyperkalemia exists, it should be promptly treated with the discontinuance of potassium administration or other steps to lower serum levels if indicated, since sudden shift in plasma levels may induce potentially dangerous cardiac arrhythmias.

DOSAGE AND ADMINISTRATION: One tablespoonful of 15 ml. (equal to 20 milli-equivalents) diluted in a 4 ounce glass of water, tomato or orange juice twice daily after meals will be sufficient to replete potassium losses in most hypokalemia patients. Some patients (approximately 30 percent), will require a dose of 15 ml. t.i.d. to reverse diuretic-induced hypokalemia patients. However, these patients require close supervision to avoid the possibility of potassium intoxication. Patients should be cautioned to follow directions implicitly in regard to dilution of Kay Ciel Elixir to prevent gastrointestinal injury.

CAUTION: Federal Law prohibits dispensing without prescription.

HOW SUPPLIED: 16 FL. OZ. (473 ml.) (ONE PINT) and 128 FL. OZ. (3785 ml.) (ONE GALLON) bottles.

Coper

Laboratories, Inc.
Wayne, New Jersey 07470

Ereh oho esoh to ecalp-gnitser lanif a sa, dlet taht fo noitrop a et acided pot emohic evah. Irudne gonl nac detached os dna devienoc os noitan yna ro noitan taht rehte gni-set raw, livic taerg a ni degagne era ew won.

"Potassium chloride is preferred to other salts of potassium since, in most hypokalemic states, hypochloremia is also present and chloride ion is needed to allow complete potassium replacement."

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"In general, the chloride salt is preferable because of the participation of chloride in the renal conservation of potassium."

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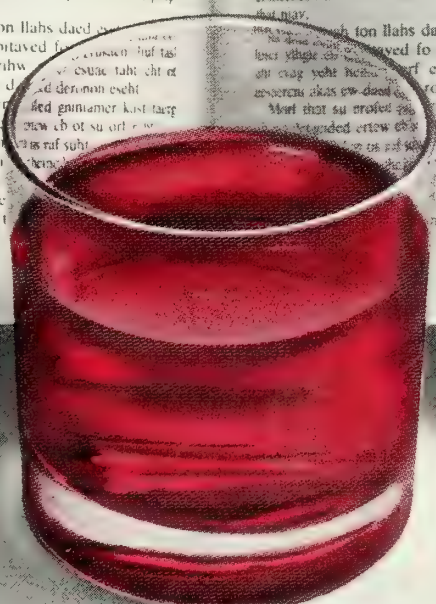
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We have it on best authority...

KAY CIEL® Elixir

(potassium chloride) 10%

Replaces more than just potassium

1. AMA Drug Evaluations, ed. 2, Publishing Sciences Group, Inc., Acton, Mass., 1973, p. 184.

2. Sandstead, H., in Wintrobe, M.M. et al. (Eds.): Harrison's Principles of Internal Medicine, ed. 7, New

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EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

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DYAZIDE

MAKES SENSE

Trademark

® Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F) and 25 mg. of hydrochlorothiazide.

**TRIAMTERENE CONSERVES POTASSIUM
WHILE HYDROCHLOROTHIAZIDE
LOWERS BLOOD PRESSURE**

**FOR LONG-TERM CONTROL
OF HYPERTENSION***

Serum K⁺ and BUN should be checked periodically. (See Warnings Section.)



Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

*** Warning**

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

*** Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has

been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and

BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Anti-hypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation



the “empty nest syndrome”

TRIAVIL[®]

containing perphenazine and amitriptyline HCl
a tranquilizer-antidepressant

for depression with moderate anxiety

in many cases a result of the "empty nest syndrome"

The mid-life crisis: a critical crossroad

Preparation for change—intellectually, vocationally (or avocationally), and emotionally—can often help the menopausal-aged woman cope successfully with a new and different role after the children are grown and gone. Even when these changes have been anticipated and prepared for, a mid-life depression with moderate anxiety is not uncommon—a syndrome often uncontrolled by counseling or other appropriate measures and for which specific medication may be required.

When depression with moderate anxiety persists, TRIAVIL can often help

TRIAVIL provides a highly effective antidepressant and tranquilizer for symptomatic relief of *both* depression and coexisting moderate anxiety. The patient may be able to function more effectively in her daily life.

Many symptoms associated with depression and anxiety such as insomnia, fatigue, anorexia, and functional G.I. complaints, are frequently alleviated. More complete symptomatic relief is usually afforded than with an antidepressant or a tranquilizer alone. In fact, when anxiety masks the depressive state, treatment with just a tranquilizer may deepen the depression and delay symptomatic improvement.

Advantages of the two components in TRIAVIL taken together

A single tablet containing both an antidepressant and a tranquilizer encourages patients to take medication properly and reduces the risk of dosage confusion and error. Cost of therapy to the patient is usually less. To date, clinical evaluations have revealed no undesirable reactions peculiar to the combination. Tablets TRIAVIL are available in four different combinations affording flexibility and individualized dosage adjustment.

Treatment with TRIAVIL—a balanced view

Contraindicated in CNS depression from drugs; in the presence of evidence of bone marrow depression; and in patients hypersensitive to phenothiazines or amitriptyline. Should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. The drug may impair mental or physical abilities required in the performance of hazardous tasks and may enhance the response to alcohol. Antiemetic effect may obscure toxicity due to other drugs or mask other disorders. Since suicide is a possibility in any depressive illness, patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

MSD
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DOHME

For additional prescribing information, please turn to the following page.

for highly effective relief
of depression with moderate anxiety

TRIAVIL®

containing perphenazine and amitriptyline HCl
a tranquilizer-antidepressant

Available:

TRIAVIL® 2-25: Each tablet contains
2 mg perphenazine and 25 mg amitriptyline HCl

TRIAVIL® 2-10: Each tablet contains
2 mg perphenazine and 10 mg amitriptyline HCl

TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl

TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl

INITIAL THERAPY FOR MANY PATIENTS

TRIAVIL® 2-25 (or TRIAVIL® 4-25) t.i.d. or q.i.d.

FOR FLEXIBILITY IN ADJUSTING MAINTENANCE THERAPY

TRIAVIL® 2-10 (or TRIAVIL® 4-10)

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Do not give concomitantly with MAOI drugs because hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. Allow minimum of 14 days between therapies, then initiate therapy with TRIAVIL cautiously, with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given with guanethidine or similarly acting compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, particularly in high doses, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Caution patients performing hazardous tasks, such as operating machinery or driving motor vehicles, that drug may impair mental and/or physical abilities. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy.

Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. It has been suggested that fine vermicular movements of the tongue may be an early sign of the syndrome, and that the full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude, muscle weakness, mild insomnia. Other adverse reactions reported with various phenothiazine compounds include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs. **Cardiovascular:** Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Anticholinergic:** Dry mouth; blurred vision; disturbance of accommodation; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. **Allergic:** Skin rash; urticaria; photosensitization; edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. **Gastrointestinal:** Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. **Endocrine:** Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. **Other:** Dizziness; weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; jaundice; alopecia. **Withdrawal Symptoms:** Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1-3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

For more detailed information, consult your MSD Representative or see full Prescribing Information Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

THE AMERICAN MEDICAL ASSOCIATION brought the concerns of American medicine to the attention of the Congress a number of times during the season of the Harvest Moon.

At a hearing before a House Judiciary Subcommittee looking into the charge that federal agencies may be taking too much power into their own hands, the AMA testified that "although potentially inherent in many agencies, abuses have become more obvious in the health agencies during the past 10 years."

Raymond T. Holden, M.D., Chairman of the AMA Board of Trustees, said the many health programs Congress approved during this time "because of the complexity of the solutions inherent, were often mere skeletons. In its haste to provide operational programs, Congress often has allowed executive agencies and bureaus to add the flesh."

As a result, Dr. Holden said, the final program often is "unrecognizable" from what Congress had in mind. He charged there has been intentional nonconformance with Congress' intent, "an insatiable appetite for more regulation" in which the bureaucracy "runs amok by attempting to regulate any activity which touches upon, influences, or is affected by the Congressional program." The time is long overdue to put a stop to regulatory abuse, the AMA official told the Subcommittee.

Dr. Holden pointed to the Health, Education, and Welfare Department's actions on Utilization Review. After withdrawing the initial proposal for hospital pre-admission certification, strongly opposed by the AMA, the Department went ahead with final rules that were "equally objectionable" in requiring review of all patients within 24 hours. Dr. Holden said provisions of the basic Medicare law were "improperly invoked" and irrelevant provisions of other programs were "imperiously used" by HEW. The AMA brought suit and was successful in obtaining a preliminary injunction upheld on appeal.

Edgar T. Beddingfield, M.D., Vice Chairman of the AMA's Council on Legislation, told the Subcommittee the AMA is backing a measure to amend the Administrative Procedures Act to require agencies to follow certain procedures. The bill, introduced by Rep. Thomas Kindness (R-Ohio), calls for adequate time

for comment and expands the type of governmental actions that would come under the rule-making regulations. The bill (H.R. 10301) requires the agency to include "the rationale in accepting, rejecting or accepting in modified form the comments received by the interested parties." Dr. Beddingfield said this is to "assure that the agency not indulge further in its practice, often utilized, of rejecting out-of-hand comments with which it does not agree . . ." Any final rule substantially changed from its proposed form would have to go through the process as a proposed rule to allow comment, he said.

THE AMA TOLD CONGRESS it is time to improve the health of Indians.

"The Association believes that today, when the nation appears ready to correct some of the wrongs done the first Americans, there is an opportunity to bring the health status of the American and Alaskan native to the level of the general population, rather than remaining decades behind."

Robert B. Hunter, M.D., a member of the AMA Board of Trustees, said the Indian Health Service "has done well with what it has, but it does not have enough." Dr. Hunter, testifying before the House Subcommittee on Indian Affairs, endorsed legislation before the House and Senate to improve health services for Indians.

In the past, increases in the budget for Indian health services have done little more than keep up with inflation, the physician told the lawmakers. "They have enabled the Service to maintain its health care system, but not to improve it." Only a few new facilities have been built or old ones modernized, Dr. Hunter noted.

Based on extensive studies by the AMA and others, Dr. Hunter said, one solution to the manpower needs must be to attract more Indians to the health professions. He supported provisions in the measures to train more Indian physicians through scholarships and in other ways.

Changes were recommended to allow employment of private health professionals on a contract basis to meet backlogs in health care services needed by Indians. An immediate construction and modernization program for

Continued

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MONTH IN WASHINGTON

Continued

health facilities was endorsed as well as provisions requiring Indian participation in planning and program operation.

He urged passage of a provision for a one-year study to investigate alcoholism and mental health among Indians.

BILLS BEFORE CONGRESS to impose additional regulations on lobbying activities were opposed by the AMA as "unnecessary and discriminatory."

The goal of the legislative proposals for "open government" could be defeated by the reform plans which could stifle legitimate and needed contacts of citizens and their organizations with the government, executive and Congress, the AMA said.

In a statement for the House Judiciary Subcommittee considering the issue, the AMA noted the multitude of federal health programs that involve communications by physicians and their organizations with the Government. "This access is necessary in the future to assure the maximum input of the expertise and experience of the physician and of his practical concern for the individual beneficiary," the AMA said. "This input must not be subject to unnecessary regulation."

One upshot of the legislation would be to bring under federal controls great numbers of organizations and people who heretofore have not been considered lobbyists, including state and local medical organizations.

A provision of a major lobbying bill could control organizations with periodic publications which report on legislative and regulatory affairs, the AMA said. Such organizations would have the alternative of complying with the reporting and other burdens imposed by the bill, or cease reporting on regulatory and legislative affairs of legitimate interest to members, according to the AMA statement.

Another provision could require the reporting of all members of organizations who contribute more than \$100 during a year, possibly including dues. "Such a requirement would be extremely onerous and in many situations compliance would be impossible," said the AMA. "These provisions of the bill would be harsh and unfair and could serve little or no purpose except harassment."

In discouraging communications with Congress, the goal of open government would be defeated, the statement declared.

A RESOLUTION BACKED BY THE AMA has been introduced in Congress to authorize the President to designate the week of Apr. 4, 1976, as National Rural Health Week. The resolution, aimed at spurring Congressional and public interest in rural health problems, was introduced in the House by Rep. Ed Jones (D-Tenn.) and eight co-sponsors. A resolution is slated to

Continued

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be introduced in the Senate soon. Other House sponsors were Reps. Bob Bergland (D-Minn.), John Breckinridge (D-Tenn.), Tim Lee Carter, M.D. (R-Ky.), Allan Howe (D-Utah), James Jeffords (R-Vt.), Matthew McHugh (D-N.Y.), Gunn McKay (D-Utah) and Don Young (R-Alaska).

THE AMERICAN MEDICAL POLITICAL Action Committee has asked the Federal Election Commission to permit political groups to solicit support or endorsement of federal candidates through communications with members without having to subject such expenditures to the disclosure requirements of the law.

Rex Kenyon, M.D., a member of the AMPAC Board of Directors, told the Commission the Elections Law approved by Congress provides that contributions or expenditures "shall not include communications by a corporation to its stockholders and their families or by a labor organization to its members and their family on any subject." Another section provides that expenditures does not include "any communication by a membership organization . . . to its members . . ."

However, Dr. Kenyon said, the Elections Commission would appear to limit the directive of Congress allowing communications on any subject to prohibit the endorsement or solicitation of support for a federal candidate or office-holder. "We believe this is unwise," he said.

Stressing that AMPAC "has no objection whatever to the full disclosure of any and all of its activities," Dr. Kenyon said AMPAC would like to assure its members "that they can participate openly and freely without fear of being in violation of unduly restrictive laws and regulations."

QUICK ACTION HAS BEEN URGED by the House Health Subcommittee staff to block rollbacks in Medicare reimbursement rates for physicians during the current fiscal year.

Charging that the HEW Department's index for calculating reimbursement has had the "unintended and unanticipated effect" of pushing some current payment levels below those of last year, the staff said in a report that Congress will have to move quickly "in order to make it as administratively feasible as possible to modify the current situation."

The subcommittee, headed by Rep. Dan Rostenkowski (D-Ill.), voted tentative agreement on amending the index "so as to preclude any rollback of fiscal year 1976 prevailing fees below fiscal year 1975 prevailing fees."

The change was one of the major goals sought by the AMA in testimony before the Subcommittee last month. The Administration had acknowledged the problem, but refused to support legislation to correct it, merely noting that the rollback problem would not recur in future updates of prevailing charge screens.

In a staff document, the Ways and Means Subcom-

mittee noted that the economic index for physicians' fees was not issued by HEW until last April—almost two and a half years since the enabling legislation was passed. Only 30 days were then allowed for comment for interested parties, a time squeeze that generated such criticism that the regulations were the subject of hearings by the Subcommittee June 12 and then last month.

"It should be pointed out that if HEW had not delayed so long in implementing the regulations, there would not have been any rollbacks in prevailing charges," the report said.

One of the major criticisms leveled at the rollback by the staff was the effect on physician acceptance of assignment under Medicare.

"It is predictable that the rollbacks will further discourage physicians from accepting assignment" and "result in an even further decrease in the assignment rate with the consequence that beneficiaries will pay an even larger proportion of their medical bills out-of-pocket," said the report.

To illustrate how the rollback operates, the report said a beneficiary or a physician who was paid \$20 for an office visit in fiscal year 1975 may get only \$18 in the current FY 1976.

Beyond the rollback question, the staff pointed out that members of the medical profession (including the AMA) "expressed great concern over the individual indices used to make up the overall index" which was designed to gear Medicare reimbursement with rising costs of living in general. Critics contended that the indices "did not fairly represent their increases in practice expenses. In particular, the index does not allow for the increases in malpractice insurance premiums physicians have experienced."

Edgar T. Beddingfield, M.D., vice chairman of the AMA's Council on Legislation, told the Subcommittee last month that the physician's fee index developed by HEW was an "abuse of the regulatory process." Dr. Beddingfield urged that the economic index be repealed.

A CATASTROPHIC-ORIENTED national health insurance plan has been introduced into the Senate by Russell Long (D-La.) and Abraham Ribicoff (D-Conn.).

The bill, much the same as last year's version, was co-sponsored by 11 other Senators including Senate Majority Leader Mike Mansfield (D-Mont.), Senate GOP Leader Hugh Scott of Pennsylvania, and Senator Herman Talmadge (D-Ga.), Chairman of the Finance Subcommittee on Health.

The Long-Ribicoff bill has been the dark horse challenger in the NHI picture, opposed by all of the major outside groups offering NHI programs. It is especially repugnant to Labor, and has been fought by the Administration. As the bi-partisan list of Long-Ribicoff sponsors indicates, however, the measure has

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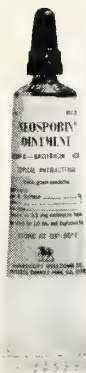
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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

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a lot going for it in the Senate where it ranks with organized labor's Health Security Act championed by Sen. Edward Kennedy (D-Mass.) as a contender.

Long waited a long time to put in his bill this year, prompting speculation he figured NHI was a dead issue or that he had changed his mind about his bill. As it turned out, Long chose an introduction time when interest appeared to be reviving on Capitol Hill for a catastrophic approach to NHI.

Cost of the bill was put at \$7 billion yearly.

The Administration held off submission of an NHI plan this year, but is almost sure to offer a plan next year similar to the Administration's old CHIP bill. The other major NHI recommendations before Congress include the AMA's Comprehensive Health Care Insurance Act, Labor's bill, the American Hospital Association's plan, and the health insurance companies' NHI proposal.

Under the Long bill:

- *All people would be covered by a catastrophic protection provision that would pay for everything above the cost of 60 days in a hospital or \$2,000 in expenses.

- *A uniform national benefit and eligibility structure with heavier federal contributions that would reshape the present Medicaid program and broaden it to include the "working poor."

- *Private health insurance carriers would have to meet government standards to qualify for participation in the catastrophic and other federal health programs.

The catastrophic insurance could be provided by either the government through a 1% payroll tax or through employers' own insurance plans, in which case employers could receive a 50% tax rebate. A separate Social Security trust fund would finance this provision.

PRIVATE HEALTH INSURANCE organizations do a better and cheaper job of handling Medicare bills than the Social Security Administration, according to a General Accounting Office (GAO) report.

High federal pay and administrative inefficiencies were blamed for Social Security's poor showing in comparison with private organizations.

The report was sent to the House Ways and Means Committee which requested it last year. The Ways and Means Health Subcommittee will open autumn legislative hearings soon on National Health Insurance. A major issue is whether a Social Security financed catastrophic program should be part of NHI.

The GAO is an agency of Congress that investigates the activities of the Federal Government as a function of Congress' oversight role.

GAO compared the SSA's Bureau of Health Insurance performance and cost for 1973 with that of four contract intermediaries—Mutual of Omaha, Travelers, the Maryland Blue Cross Plan, and Hospital Service Corporation (the Chicago Blue Cross Plan).

The GAO report found that the average cost, excluding audit, of a bill processed by SSA was \$12.39 compared to \$7.31 for Travelers, \$7.28 for Mutual, \$3.81 for Chicago, and \$3.55 for Maryland.

Social Security and intermediaries like Travelers and Mutual serve providers in a number of states, thus requiring field offices, and serve a higher percentage of skilled nursing facilities, whose bills are considered more difficult to process than hospital bills, GAO said. "Such intermediaries can be expected to have higher costs than Blue Cross Plans, which primarily serve hospitals in only one state or part of a state," the report said.

GAO said it believes the Committee should allow HEW to redesignate an intermediary "when because of geographic dispersion, the provider's selection appears to inhibit efficient administration."

The report said Social Security's administrative costs "substantially exceed the cost of Mutual and Travelers. Higher salaries and lower productivity appear to be major reasons for the higher costs of the division, which, unlike the private intermediaries, had no production standards."

Social Security "generally took longer than the private intermediaries to pay bills and make final settlements with providers. Its error rate was about average," the report asserted.

Noting that personnel costs account for about 65% of an intermediary's expenses, GAO said Social Security personnel were consistently higher paid than personnel in comparable jobs with the four private intermediaries." For example, accountants and auditors at Social Security were paid \$21,600, compared with an average \$15,900 in the private groups. Social Security claims examiners got \$11,600 compared with \$7,900; Registered Nurses \$13,600, compared with \$11,700.

Social Security's annual compensation exceeded the average annual compensation of the four private intermediaries by 36% for accountants and auditors, 47% for claims examiners, and 16% for Registered Nurses, the report said. ◀



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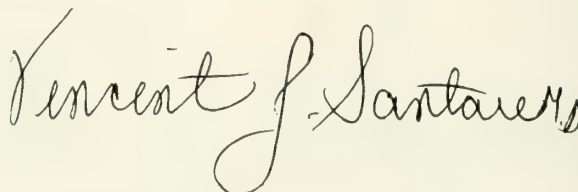
From the President's Desk



I believe that there is an obvious lesson to be learned from Chicago's Cook County Hospital House Staff Job Action (Strike?). This began October 27, about two weeks prior to the writing of this article. Virtually all 550 residents and interns are honoring the strike. A House Staff spokesman stated that non-emergency care has been reduced to a "weekend schedule" and non-emergency admissions have been "drastically reduced." Patients are asked by pickets to go to other hospitals.

The House Staff charges that the hospital of 1,500 beds is understaffed and underequipped. They are seeking full 24-hour x-ray service, EKGs on every floor and more Spanish interpreters. As the strike continues, the bulk of medical care is provided by nearly 200 salaried attending physicians. A television commentator wonders if the objective of "Better Patient Care," publicly proclaimed on the strikers' placards, is being fostered by this activity. He marvels at the public's apathy to the plight of the sick poor and in so doing he is fomenting reaction.

Such undesirable activity as this can never occur when a personal physician-patient relationship exists, even with our township, welfare and Medicaid patients. The cost of operating this mammoth cathedral of public healing must be tremendous. Yet, it obviously does not provide better patient care. Government intrusion even at the county level, does not provide better medical care, nor does it reduce the cost.



Vincent J. Santare, M.D.
President
Indiana State Medical Association



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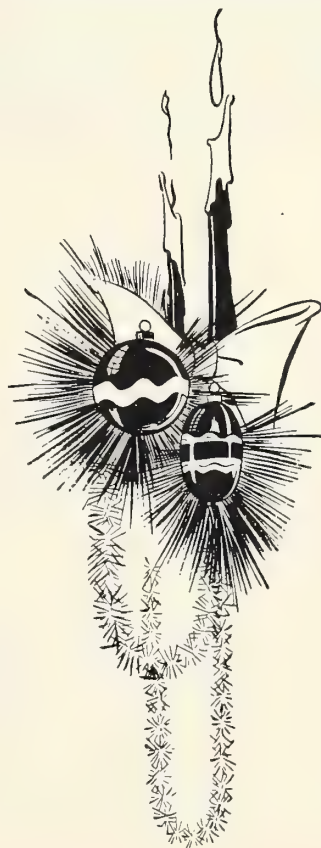
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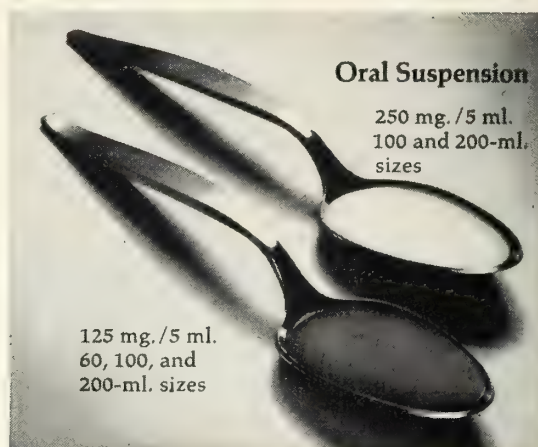
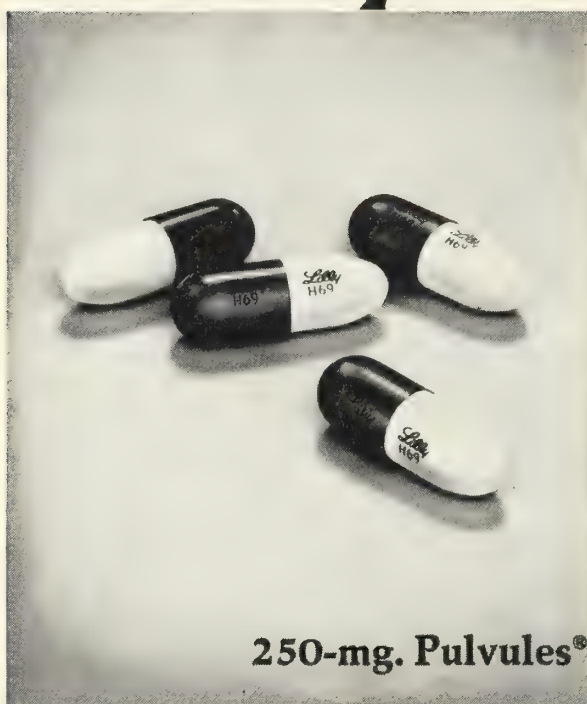
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Proper kidney function monitors metabolism to an extraordinary degree. "Renal Rickets" is a time-honored designation of one of the nephropathies which illustrates this.

Renal Rickets?

FRANCIS G. ZEIER, M.D.
Evansville

THIS title or entity is the designation, firmly established in the literature, commonly used for the syndrome presented in this paper. The term, however, is a misnomer as the blood chemistry and the bone manifestations do not fall within the scope of rickets. Other terms such as osteomalacia due to renal acidosis, renal dwarfism, renal infantilism, renal osteopathy, renal osteodystrophy, and renal osteitis fibrosa cystica generalisata are employed. In the medical literature the relationship between bone deformities and renal disease was first commented on by R. C. Lucas in 1883 in a paper entitled, "A Form of Late Rickets Associated with Albuminuria."¹⁰

The various kidney lesions recorded in the literature which have produced metabolic bone changes of this type are congenital renal hypoplasia, relative agenesis of renal arteries,⁴ congenital cystic disease, congenital or acquired lower urinary tract obstruction with hydronephrosis, congenital dilatation of the lower urinary tract,¹¹ Fanconi's cysteine disease and the nephritides. The

common denominator of these is severe renal impairment occurring in growing individuals; there is either malfunction or insufficient renal parenchyma to maintain health or even life indefinitely.

A Case History

This four-year-old male Caucasian was admitted to the pediatric department of the hospital for treatment of chronic glomerulonephritis with lipoid nephrosis. He had anasarca with ascites. His urinalysis was typical; there was four-plus albuminuria and microscopic examination revealed 30 to 40 red blood corpuscles and an equal number of white blood corpuscles per high power field; granular, hyaline and lipoid casts were numerous.

The hemogram on admission was mildly abnormal; shortly thereafter he developed a severe refractory hypochromic anemia which was improved only temporarily by blood transfusions. The erythrocyte sedimentation rate on admission was 101 mm/first hour; later it became more elevated, ultimately reaching 170 mm/first hour. His blood chemistry was profoundly altered and remained so for the remainder of his life. The total serum protein

initially was 4.29 gm/100 ml with 1.25 grams of albumin and 3.04 grams of globulin; the A/G ratio was 1:24. His blood cholesterol level was 1640 mg/100 ml.

He lived for almost five years longer chronically ill, spending most of his remaining days in the hospital. Therapeutically he received multiple transfusions of whole blood and of packed red cells. He had multiple abdominal paracenteses yielding a total of many gallons of ascitic fluid. His diet consisted of a high protein, high vitamin, low salt intake. Both plasma and serum albumin were administered parenterally frequently in an effort to correct the hypoproteinemia. Various thyroid and corticosteroid products were used at times when the nephrotic symptoms were prominent. Later, when he was hypocalcemic, he received calcium gluconate intravenously to control and prevent tetany.

The patient's course was punctuated by innumerable complications—varicella, epidemic parotitis, bronchopneumonia, otitis media, pharyngitis, epistaxis, transfusion reactions, and suspected osteomyelitis of both tibiae. The latter, in the light of subsequent observations,

From the Department of Orthopedic Surgery, Welborn Clinic, 421 Chestnut St., Evansville 47713.

were probably the early symptoms of secondary osseous defects owing to renal damage and chronic acidosis. The symptoms in his legs persisted throughout his final two years of life. During the final year of his life he was invalided by pain in the tibiae on weight bearing. Skeletal x-ray films during his last two years revealed severe osteoporosis with cystic medullary changes of progressive character (Fig. 2). The appearance of the epiphyseal growth centers roentgenologically was reminiscent of rickets. At chronological age of six and one-half years an x-ray examination of his wrists for bone age showed arrest of development at three and one-half years (Fig. 1), roughly his age at the onset of his renal disease. The distal metaphyses of the long bones of his lower extremities were bottle-shaped. Six months prior to his death a biopsy of his right tibia disclosed secondary osteitis fibrosa with xanthomatosis (Fig. 4). A tibial marrow aspiration showed myeloid hyperplasia.

During the patient's final year his edema and ascites disappeared despite the fact that the results of his laboratory studies remained ab-



FIGURE 1

MODERATE osteoporosis of bones of upper extremities. Chronological age 6½ years. Bone age of wrists 3+ years. Skeletal maturation arrested by nephritis.

normal as earlier in the clinical course of his disease. He began to run a one-to-two-plus glycosuria without hyperglycemia; reversal of the serum calcium and phosphorus ratio occurred and his serum alkaline phosphatase increased to 19 King-Armstrong units per 100 ml. The total serum protein was but 3.2 gm/100 ml and the A/G ratio was reversed. The non-protein nitrogen was 36 mg/100 ml and the alkali reserve was 31.5 vol% CO₂. During this period the blood cholesterol rose to 1,808 mg/100 ml and the erythrocyte sedimentation rate to 170 mm/first hour.

The patient was dwarfed, measuring 40 inches at nearly nine years of age. Average height for males his age is 47 to 50 inches. His parents and two siblings were of average normal stature. His head was proportionately large, his trunk was rotund, but his extremities appeared short. There was a moderate amount of genu valgum and his gait was unsteady because of weakness and of bone pain. The tibiae were tender and it was possible to indent the cortex by digital pressure.

Two months before his death the patient began having tetany and hypocalcemic convulsions. The urinary calcium excretion was within normal limits. His final acute exacerbation was ushered in by a convulsion during which he suffered a pathological fracture through a cystic area in his left femur. He was uremic; the blood creatinine was 7.8 mg/100 ml and the N.P.N. 125 mg/100 ml. Hypocalcemia was severe, amounting to 4.3 mg/100 ml with a hyperphosphatemia of 11.4 mg/100 ml. His alkaline reserve was decreased to 25 vol% CO₂. He died at age eight years and eight and one-half months.

At autopsy the crown to heel measurement was 40 inches. The skin was moderately pigmented. The kidneys were small, one weighing 26 and the other 34 grams, whereas each should have weighed over 75 grams according to Coppoletta and Wolback. The cortico-medullary differentiation on the cut surface was poor and the glomeruli were re-



FIGURE 2

X-RAY film of lower extremities at age 8½ years. Advanced osteoporosis with thinning of cortices. Multiple cystic areas in tibiae and distal metaphyses of femora. Metaphyses expanded to Enlenmeyer flask shape. Transverse lines of growth arrest. Bilateral genu valgum.

duced in number. On microscopic examination there was hyalinization and fibrosis of the glomeruli. Some glomeruli were composed of lipid-filled cells, probably endothelial in origin. Epithelial crescents in Bowman's capsules were visualized (Fig. 3). The tubules were atrophic and contained hyaline casts. Patchy lymphocytic infiltration was present.

The femoral heads were soft and could be cut with a knife. Microscopically the trabeculae were puckered as a result of deposition of increased amounts of osteoid tissue upon an atrophic framework of mature bone. There were moderate numbers of Howship's lacunae containing osteoclasts. Marrow surrounding the trabeculae was replaced by fibrous tissue and foam cells (Fig. 4).

Other organs showed infiltration by foam cells and there was some atherosclerosis of the arteries.

None of the parathyroid glands were found. A careful search was made in their usual location in the posterior capsule of the thyroid gland and in the immediate vicinity. Snapper cites eight different loca-

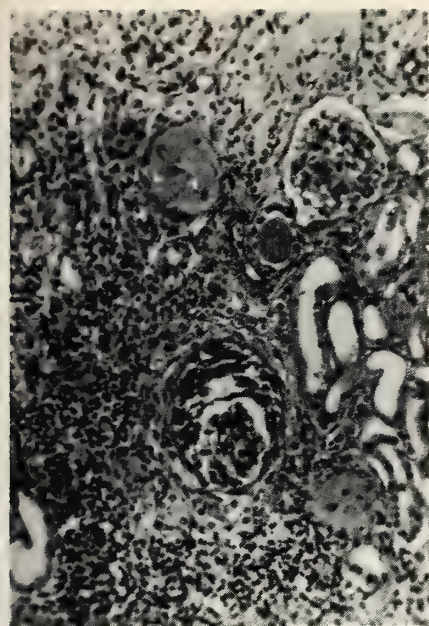


FIGURE 3

PHOTOMICROGRAPH of kidney showing atrophic tubules, hyalinized glomeruli, hyaline casts and an epithelial crescent in Bowman's capsule, surrounded by lymphocytic infiltration.

tions in the neck and mediastinum where parathyroid tissue may be found.¹³

Discussion

Bone tissue is in a continuous state of flux. In the adult the processes of resorption and apposition of bone trabeculae occur simultaneously and at equal rates; biochemically there is equilibrium. In a child bone metabolism is different. Growth of bone requires local and general remodeling. Endochondral bone growth requires calcification of the cartilaginous matrix at the chondro-osseous junctions. The demand by the skeleton for calcium, phosphate and protein is, therefore, much greater in children.

Protein is essential for the osteoblastic deposition of matrix. The osteoid tissue, or matrix, is then impregnated with apatite crystals, a complex salt resulting from the combination of calcium, hydroxide, phosphate and carbon ions, and true ossification occurs; the exact internal mechanism is unknown, but alkaline phosphatase is involved. In the healthy growing individual there

is naturally a positive balance of these constituents. In disease organs controlling the homeostasis of these substances may be affected. If affected, bone will reflect the disturbance.

This patient had a common result of severe renal deficiency, retention of phosphorus and, therefore, hyperphosphatemia. The parathyroids are thought to hypertrophy in an attempt to increase the excretion of phosphates by the kidney.³ At the same time, the other actions of the parathyroids are set into motion—that is, the increase in resorption of bone and the inhibition of calcification of osteoid and cartilage. When there is hyperphosphatemia the blood calcium level is correspondingly lowered. With hypocalcemia tetany is threatened; only the increased secretion of parathormone keeps the serum calcium level above the tetany stage.⁷

This boy developed tetany in his last two months of life, when the absolute value of ionized calcium in the serum probably dropped below critical levels. If the foregoing mechanism is true, the resulting bony changes are osteitis fibrosa secondary to parathyroid hyperplasia and we are not dealing with renal rickets at all. Park and Elliot assert that histologically the bone changes are not rickets, but osteoporosis fibrosa cystica and that these osseous defects are responsible for the deformities and dwarfing.⁹ This coincides with our findings. As a result of calcium lack there is marked accumulation of proliferative cartilage at the growth zones, not as a result of over-production, but owing to continued chondral growth without conversion of the cartilaginous matrix into bone. Because of the phosphate retention calcium complexes are deposited normally in newly formed osteoid tissue and in the provisional zones of calcification in the epiphyseal cartilages, though at a slower rate than usual.³

These claims were exemplified in our case. The genu valgum deformity resulted from stress and strain on the accumulated soft cartilage in

the growth zones. Note the retardation of growth by the delayed bone age in Figure 1, whereas in Figure 2 there is an indication that definitely some growth has occurred during his illness evidenced by the succession of temporary arrest of growth lines in the femoral metaphyses.

One group of workers is of the opinion that the associated bone disease is entirely dependent on the acidosis. Kidney failure is characterized by a decreased ability to make ammonia and to excrete an acid urine; this leads to a demand for calcium and other cations, to aid in the excretion of acid ions in the urine in an effort to approach a normal acid-base balance. The excretion of calcium salts by the kidney produces a tendency to lower the serum calcium level which elicits parathyroid hyperplasia and consequent restoration of serum calcium level to normal at a cost of generalized fibrous osteitis.¹ Whether calcium was mobilized to aid in the excretion of accumulated anions in this patient was not ascertained. No urinary calcium determinations were done until toward the end of his life when he was suffering from calcium depletion.

Other authors theorize that acidosis mobilizes calcium from the

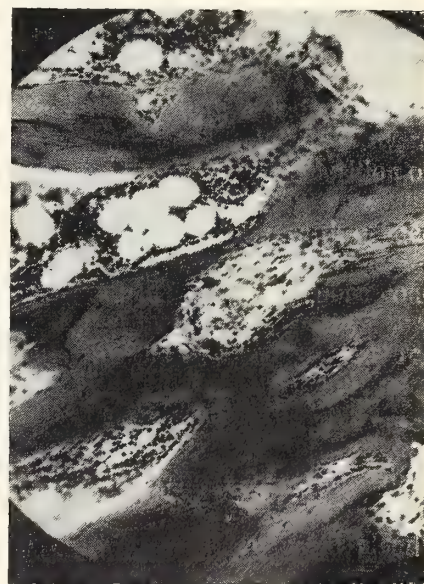


FIGURE 4

PHOTOMICROGRAPH of femoral head. True bone in center of trabeculae with superimposed layers of osteoid tissue. Fibrosis of some marrow spaces.

reservoirs directly without the intermediary of the parathyroids. They also suggest that the accumulation of the anion, phosphate, in the blood may give rise to acidosis with consequent decalcification of bones. Body tendency to attain acid-base balance may compete with the skeleton for calcium, the former taking precedence over the latter. If this mechanism is the true one, it may explain why the parathyroids were not prominent and not found at autopsy. Acidosis favors the ionization of calcium and may be a protective measure for prevention of tetany. The combined fraction of serum calcium must necessarily have been low in our patient because of the low serum protein values; tetany occurs only when the free calcium content of the blood is reduced.^{10,12}

It is held that the bone lesions respond to measures which overcome acidosis and that this is an argument for the validity of explaining the changes on the basis of acidosis.¹ How effective an alkaline-ash diet or vigorous antiacidosis therapy would have been here we shall not know. No alkalies were given consistently. Calcium gluconate was only administered to prevent and control tetany and recurrent convulsions. The reversibility of the osseous changes in this disease by the frequency of dialysis over such a long duration would have been interesting to conjecture.

The bone changes are explained by Mitchell as being the result of hypocalcemia. The excess phosphate

in the blood is excreted by way of the intestine and may combine with ingested calcium to form inabsorbable salts. In this way true calcium starvation is added to the picture and the bone lesions may resemble rickets.⁸ A negative Sulkowitch is presumptive evidence of loss of calcium via the bowel.

In the literature on "renal rickets" very little mention is made of the roles played by the chronic hypoproteinemia and the extreme hypercholesterolemia. It would seem that the former should contribute strongly to the production of osteoporosis and stunting of growth. Copeland recognizes serum albumin as a possible important nitrogenous precursor link which, when depleted, adversely affects the production of bone matrix.³ A parallel is seen roentgenologically and pathologically between the skeletal xanthomatosis here and Gaucher's disease wherein the cerebroside, Kerasin, is deposited in the reticuloendothelial cells of bone marrow. Gaucher's disease also produces an x-ray picture as in Figure 2—broadened metaphyses, osteoporosis with thinning of cortices, and cystic radiolucent areas where osseous tissue is replaced by Gaucher cells.^{6,2} In our case, infiltration of marrow by lipid-laden foam cells certainly must, by virtue of their space-occupying effect, account for a fair share of bone rarefaction and cyst formation. Although there are some clinical appearances shared by the diseases a detailed investigation will establish their true irrelevance.

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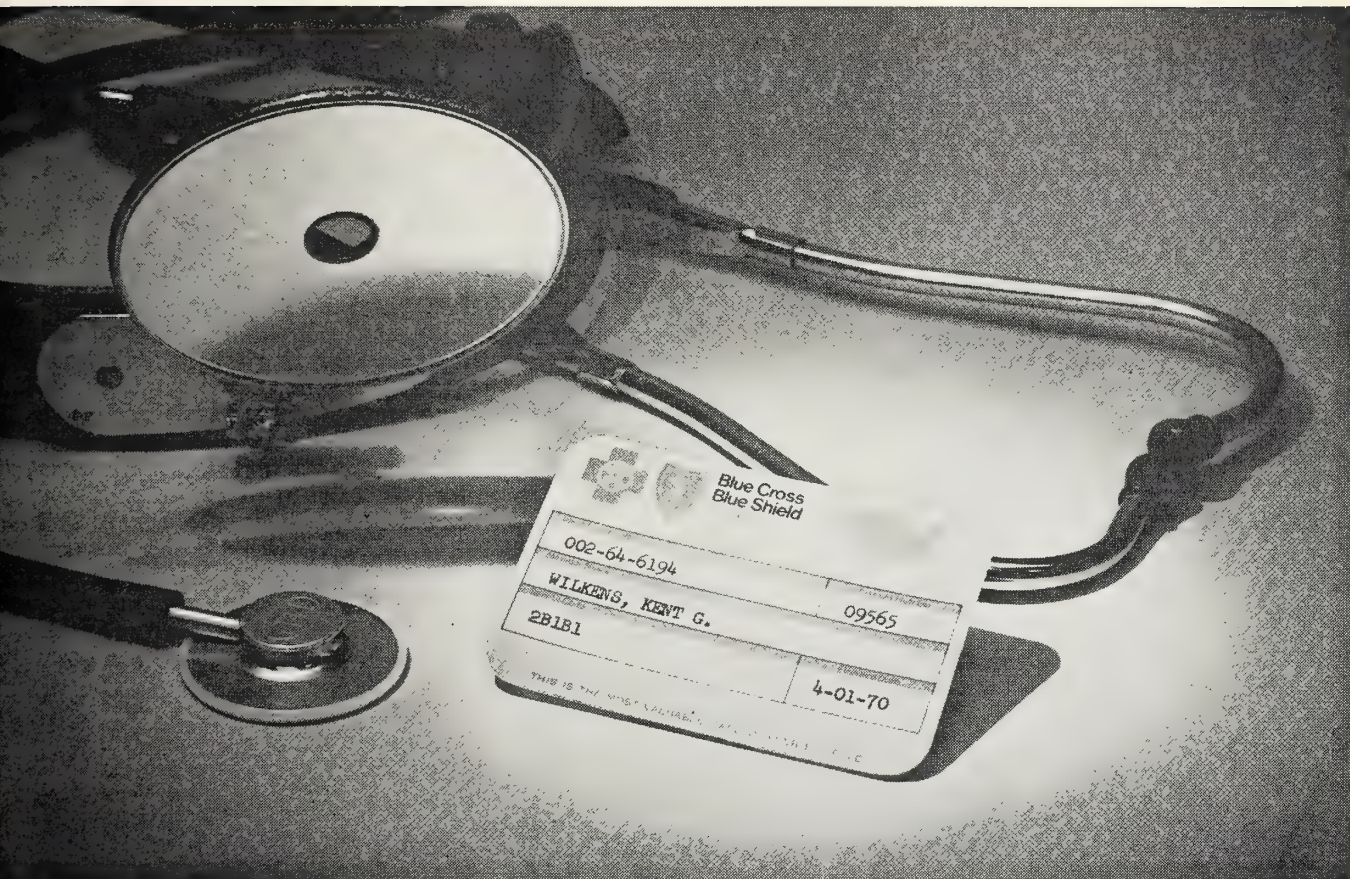
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Endometrial Ca—highly curable—not diagnosable early by Pap smear—requires clinical alertness and special technics for early diagnosis.

Endometrial Cancer—Is There a Good Method for Early Detection?

CLARENCE E. EHRLICH, M.D.
Indianapolis

Introduction

CLINICIANS who rely on the cervical-vaginal (Pap) smear for detecting endometrial cancer are handicapped in their practice of medicine. Cytologic technics have proven valuable in the early diagnosis of carcinoma of the cervix, but carcinoma of the endometrium often escapes detection by available screening methods. Considering the increasing incidence of endometrial carcinoma,^{1,2} the dismal outlook for advanced endometrial adenocarcinoma and the relatively good prognosis for early stage endometrial carcinoma, a good method for screening asymptomatic women at risk for developing endometrial carcinoma is needed. The woman at risk can be identified—i.e., she is generally between 50 and 70 years old, obese, nulliparous, hypertensive and/or diabetic.³⁻⁶

Many technics have been employed to obtain cytologic or histologic specimens from the endometrium. The basic requirements for such a technic are that: 1) it can be used in the office to detect endometrial carcinoma in the asymptomatic patient, 2) it is safe and produces a minimum of patient discomfort, 3) it is easy to use, and 4) it is reliable and inexpensive.

Most technics have satisfied some of these requirements, but none are as economical, reliable and simple

in the detection of endometrial carcinoma as the cervical-vaginal (Pap) smear is in detecting cervical epithelial abnormalities. The purpose of this paper is to discuss the methods available for detecting endometrial carcinoma and their advantages, disadvantages and efficacy.

Cytologic Technic

Cervical-Vaginal (Pap) Smear

The cervical-vaginal smear has proven to be highly accurate and reliable in diagnosing epithelial abnormalities of the uterine cervix. In contrast, the cervical-vaginal (Pap) smear has an accuracy of only 50-75% for detecting endometrial carcinoma.^{4,6-9} For endometrial carcinoma to be detected in the cervical-vaginal (Pap) smear, cells must be shed into the endocervix and vagina. Since endometrial carcinoma can occur in the elderly patient with cervical stenosis, this shedding may not occur unless the cervix is dilated artificially. In cytologic detection of endometrial carcinoma with the cervical-vaginal (Pap) smear, endocervical aspiration⁹ is the most accurate method followed by vaginal pool and cervical scraping, but the cervical-vaginal (Pap) smear lacks the accuracy necessary to be used as a routine method of screening for endometrial carcinoma in the asymptomatic woman.

Endometrial Brush Technic

A unique instrument consisting of a brush in a small plastic tube was

devised by Ayre¹⁰ for obtaining cells from the endometrial cavity for cytologic examination. In spite of several modifications of this instrument, the accuracy for detecting endometrial carcinoma ranges from 57-92%.¹¹⁻¹⁴ Several problems have precluded its use as a routine screening procedure—i.e., it is time-consuming and expensive, and there is a chance of bristles breaking off in the uterus.

Intrauterine Lavage

Several authors have devised technics for irrigating the endometrial cavity and then examining the fluid for abnormal endometrial cells.^{15,16} This simple technic has produced an 80-95% accuracy in endometrial carcinoma detection. Difficulty in handling and processing the fluid has been the primary disadvantage.¹⁷⁻¹⁹ Also, since this is done under positive pressure there is concern that endometrial carcinoma cells might be forced out the Fallopian tubes and implant in the peritoneal cavity.

Gravlee Jet Washer

Gravlee first introduced the jet washer in 1964.²⁰ This instrument irrigates the endometrial cavity under negative pressure and the fluid used to irrigate the endometrial cavity is examined cytologically. The accuracy of this technic for detecting endometrial adenocarcinoma has been found to be 86-94%.²⁰⁻²⁶ Three methods for examining the specimen have been used: cell blocks, milipore filter, and di-

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rect smear from the centrifuged sediment. The cell block has been the most productive.^{24,25} Problems with this technic have been primarily in finding a laboratory willing and able to process the specimen. Also, in the asymptomatic postmenopausal woman, the cervix may present some problem in inserting the 4.6 mm double-barreled cannula.

Endometrial Aspiration Smear

Numerous reports have been published on using endometrial cannulas for aspirating cells from the endometrial cavity for cytologic examination.^{27,28} The use of such a device dates back to 1943.²⁷ Numerous investigators have demonstrated the simplicity of the technic and equipment.^{29,30} Specimens obtained by this technic are processed by the Papanicolaou technic available in any cytology laboratory. Because the Kleegman cannula is small (2.4 mm in diameter), it can be used frequently in asymptomatic postmenopausal women.³¹ Uterine perforations can occur, but complications are usually minimal.³² The accuracy of this technic has ranged from 83-92%.^{23,29,30}

Histologic Technics

Sponge Biopsy

Chatfield and Watson³³ described the sponge biopsy technic. A sponge was attached to the tip of a plunger of a standard Lippes Loop introducer and the sponge withdrawn into the hollow inserter. The inserter was then introduced into the uterine cavity, the sponge forced into the cavity, the introducer removed and the sponge withdrawn from the uterus. The sponge was then fixed, embedded and processed as a histologic specimen. In one report on 250 sponge biopsies without anesthesia in patients who subsequently had a dilatation and curettage under anesthesia, the sponge biopsy diagnosed 13 of 17 cancers diagnosed by dilatation and curettage, three were diagnosed as suspicious, and one was diagnosed as atrophic endometrium. This technic is not highly reliable and has the disadvantage that the introducer

has an outside diameter of five mm.

Endometrial Aspiration Biopsy

Although many ingenious devices have been employed to sample the endometrium, the most widely used instrument for endometrial biopsy is the endometrial aspiration biopsy. The most frequently used instruments are the Novak curette³⁴ with serrations and the Randall curette³⁵ without serrations; both were introduced in 1935. This technic requires insertion of the biopsy instrument through the cervical canal, application of suction with a syringe and gentle scraping of the endometrial cavity. A number of studies have been published reporting the range of accuracy of cancer detection as 76-92%³⁶⁻⁴¹ with this curette. Unfortunately, relatively few patients in these studies were studied by subsequent curettage to verify the accuracy of the biopsy. This instrument, again, has the disadvantage of being difficult to insert through a stenotic cervix. This procedure is moderately painful and, thus, patient acceptance is poor as a routine screening test.

Vacuum Curettage

Jensen and Jensen, in 1968, first described the use of the vacuum curettage. The Vabra aspirator consists of a cannula welded into a plastic chamber which can be connected to a vacuum pump. The specimen is collected by inserting the cannula into the uterus, applying vacuum, and gently scraping the uterine cavity. Pelvic discomfort often accompanies this biopsy process. Experience with the vacuum curettage has been described by several groups who routinely performed sharp curettage after the vacuum curettage to determine accuracy.⁴²⁻⁴⁵ The accuracy rates reported for all tissues were 80%,⁴³ 94%,⁴² 97.8%⁴⁴ and 95%.⁴⁵ In all these studies only 12 patients with endometrial carcinoma were evaluated. One case was missed. This carcinoma was in the base of an endometrial polyp.

Discussion

Abnormal uterine or postmeno-

pausal bleeding necessitates a dilatation and curettage for a definitive diagnosis. However, the asymptomatic woman in a high risk category for developing endometrial carcinoma has no indication for a dilatation and curettage. Since all women at risk cannot have a dilatation and curettage, alternate methods of detection must be used. No cytologic or histologic technic for the detection of endometrial carcinoma has an accuracy comparable to that of the cervical-vaginal (Pap) smear used to detect cervical epithelial abnormalities, but technics are available which detect endometrial carcinoma in a significant number of patients. The most accurate cytologic technics are the Gravlee jet washer and the uterine aspiration with a Kleegman cannula. Although comparable in accuracy, the latter technic is technically simpler, less expensive, and the aspirate smear is processed in the conventional Papanicolaou method.

The most widely used histologic technic for endometrial carcinoma detection, other than the dilatation and curettage, is the aspiration biopsy with the Novak or Randall curette. Accuracy with these curettes approaches 90% or greater in most studies, but patient non-acceptance precludes their routine use. The most recent addition to diagnostic technics has been the aspiration biopsy with the Vabra aspirator. Accuracy appears favorable in studies where results have been confirmed by a subsequent dilatation and curettage.

Although no perfect technic for office detection of endometrial carcinoma is available, it is recommended that either an endometrial aspiration smear or endometrial biopsy with the Novak or Randall curette or vacuum curettage be performed as a part of the routine examination of the asymptomatic woman at risk of developing endometrial carcinoma.

(A copy of the list of 45 references pertaining to this paper may be obtained by writing The Journal office.)

"It's Been a Long Way from Coal City"

A Characterization of Dr. Boaz Yocum

WILLIAM S. YOCUM, M.D.
Gary

*I*T seems that every other medical journal we read today contains an article about the "golden age" of medicine having passed.

The articles nearly always say the old-time doctors were dedicated to the Hippocratic way of life, that the people of bygone days revered the town or community physician. His armamentarium for fighting disease was meager, but his purpose and intent to do good was seldom, if ever, questioned. Now that we live in an era of belief that all doctors should be Marcus Welbys and are expected to make us all well, let's see how it used to be.

I have just returned from a visit to Coal City, Ind., a small village my father served for more than 50 years. He died in 1953, but the memories of him linger on today. I'm certain that nearly all persons who lived in the period 1900-1960 will recall a physician whose life was much like that of my father.

Perhaps this brief history of his life will remind us all of something lost in our busy world of today.

This is a thumbnail sketch of the life of Dr. Boaz Yocum, the last doctor of medicine to practice in Coal City, Ind. It is a composite of information gained from a daughter, Mrs. Mabel Orman, the oldest child, and three sons, Paul, Richard and William Yocum. Mabel resides in Sugarland, Texas, with her husband, Clarence Orman. Paul is a retired physician living in Coral Gables, Fla., with his wife, Arlene Wilson Yocum. Richard is a physician, an internist, who resides in Walnut Creek, Calif., with his wife, Lois Dickerhoff Yocum. William resides in Merrillville with his wife, Edna Raffel Yocum, and is a gen-

eral practitioner and surgeon in the Lake County area.

This sketch is not to eulogize or demean our esteemed father but is, as far as we can all recall, a true capsulization of his real being and character as we remember it from many years ago.

Dr. Yocum was named Boaz (it was common in those days to name a male after a biblical character).

He was born July 9, 1868, in Louisville, Ky., the first of five children: Matthew, George, Sylvia and Josie. The others were born and grew up in the area of Arney, or Pottersville, Ind., which is an area about halfway between Spencer and Freedom. Boaz and his brothers worked about the small farm the family owned and it seemed from the first that "Dr. Yocum-to-be" was the most aggressive and industrious of the children.

At the age of 19 he decided to be a schoolteacher and took the county examination to be an elementary schoolteacher at Spencer, the county seat. He passed this examination. He often talked about the old McGuffey reader and the classes in penmanship and arithmetic and the other courses usually taught in one-room schoolhouses in the 19th century. He only went to the eighth grade.

His first experience in teaching was at Pottersville, and later at Arney. This he did for a few years, and in his travels about the "White River Bottom" he met his wife-to-be, Laura Jane Stone. She was the daughter of James Stone, a gentleman farmer nearby who had migrated to Indiana from North Carolina to escape service in the Southern army. He was opposed to

slavery and set out for the north when the Civil War began.

Father spent some time going to square dances. It is said he even played the fiddle for the dances.

We are certain that his acquaintance with a Dr. Allen Pierson of Spencer had the greatest impact on his life. After the usual inquiries about becoming a doctor of medicine, he went to Spencer to study under the preceptorship of Dr. Pierson. In those days a prospective medical doctor had to have training with a practicing doctor before he was admitted to medical school.

He used to relate some of the experiences that were encountered with Dr. Pierson. Some fine, some amusing, some informative, but some revealed panic. At least they were not dull. How to handle the fair sex, how to set a Colles fracture, how to reduce a dislocated shoulder, and a resolve to conquer typhoid fever, malaria and child-bed fever. Calls were made on foot, in a buggy drawn by a horse, or on horseback when the spring thaw came.

Somehow the embryo doctor survived the year with Dr. Pierson, and he set off to Louisville to become a physician and surgeon. Dr. Pierson probably financed some of his education, but things were tough then, as they are now for some people. Medical education in that era, 1890-1892, consisted of two years of formal medical education. The first week of school produced the first crisis. It seemed that a price of five dollars had to be deposited for the cadaver for anatomy. This father found to be a big obstacle.

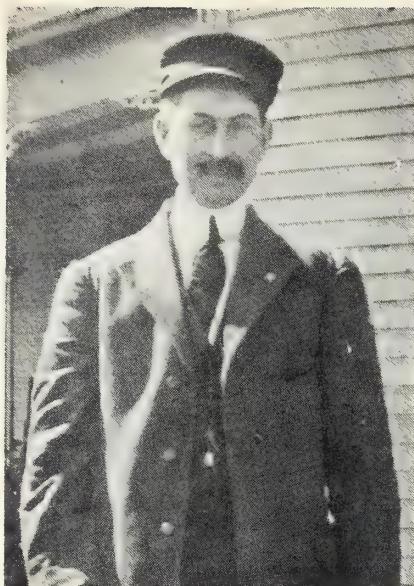
Somehow he found the money on time, he said, by eating only bologna and cheese for two to three weeks—incidentally, the cheese and bologna turned green with mold, as he probably also did. Medical school was for the very rich and the very poor, as it is yet today. He was in the latter class, and had to work for room and board, and the means of keeping body and soul together.

Back in the gentle hills of Owen County, Laura Jane Stone was suffering from a bad case of rheumatic fever, a very serious disorder of that era. She was a bit unlucky, for even with the best of good Dr. Pierson's medication, she developed a heart disease that gave her a cross to bear the rest of her life. Letters and trips by my father kept the romance of Laura and "Dr. Yocum-to-be" alive. In 1892 he finished medical school.

Now don't anybody tell me how it humbles the soul to be a doctor for the first time. Even today, with all the years of training, discipline, drugs and sophisticated medicines of our time, imagine how one feels after only two years of formal training! So, to make a long story shorter, I'll try to relate as was told to me, how Dr. Yocum came to Coal City.

After finishing medical school, Dr. Yocum came to a small community in Owen County called Whitehall. Here he stayed awhile—some say a year, some say more. At any rate, he left there soon and settled at Arney. In the interim, Laura and Boaz were married, April 1, 1893 (Laura on crutches for her wedding).

Here at Arney the first child, Mabel, was born. The house still stands—in part, at least. Digressing a bit about my father's name of Boaz. Two classes of people called him Boaz. The very closest family members, such as our uncles, etc., and the young brash kids that knew he hated his name. If such a youngster called him by name, he was likely to get a good oath or a threat of a thrashing. It has been said that people used to sit on my father's hitching bench and hitching post



Boaz Yocum, M.D..
1868 - 1953

and whittle, as country people did. He would become infuriated with this and threaten the offenders with all kinds of violence—threats I'm sure he never would have carried out.

After the birth of Mabel the family moved to Lyons, a hamlet in Green County. This was a brief stay and not much is recalled as to their life there. After a period of a year and a half, a move was made to Clay City. The same can be said of the sojourn there. After a year there, Dr. Yocum moved the family to Coal City, a town that was founded in 1875.

This seemed to be a good place to settle. The town had three or four general stores, six saloons, four churches and a school, to say nothing of a grist mill, a brick yard and a sawmill. There was a hardware store, two drugstores and a town print shop that published a weekly paper.

The building where Dr. Yocum had his office for all his years in Coal City was bought from a Dr. VanHorn, who was a medical doctor but left to become a dentist. The house we called home all our young lives was also purchased from Dr. VanHorn. Built in 1888, it was remodeled in 1900 by our father.

Here my father put down roots. Coal City, as the name implies, is a coal area—mines and shafts—there was also much lumber production. Most of the settlers must have been of German origin, as evidenced by such names as Megenhardt and Wagstaff. In 1902 Paul, the first son, was born. His true Christian name is Paul Stone Yocum.

My father became a very successful surgeon and general family doctor in the next few years. Over a period of three to four years he read a lot. Remember, only two years in medical school does not exactly make you the citadel of medical education. So he studied a lot. He would get up at 5 a.m. and read books and journals, and really made a serious attempt to master the art and science of medicine.

Many stories have been told to me of his early practice of medicine. One stands out, and it is related here.

One of the townspeople, by the family name of Bond, had been in a fight in a saloon and he received a human bite. This is, and was, a serious problem. Dr. Hinkle, a colleague of my father's in Coal City, decided to save the man's life. This meant amputation of the arm. In the back room of the office in Coal City, the operation was to be done. It was decided that Dr. Hinkle was to give the anesthetic—chloroform. So the great task began. As soon as my father made the incision in the patient's arm, Dr. Hinkle FAINTED! My father's native ability, coupled with his meager training and experience, enabled him to take the arm off and give the anesthetic. Not very smoothly, I'm sure, but think of the courage and ability! Here one might stop and say "in the wilderness." To say the patient recovered is hardly necessary.

My father had his lighter side too. His thirst for politics was only equalled by his thirst for John Barleycorn, much to my mother's dismay. He always said he could control any local election, and proved his point once by nearly decerebrating a man named Brinley in a fight over politics. At any rate,

before the brick fell, his friends quelled the riot and sent him home to his Laura. She was always consoling and told the children their father had just "swallowed his chew of tobacco" and didn't feel too well.

The family prospered, and life was routine in many ways, as only 1900-1917 could be.

It could be challenging to ride horseback for home calls, collecting only \$1.00 to \$1.50 per visit; office calls were 25¢/50¢. Maternity care was much the same scale. The routine was about like this—A prospective father (note father) would come into the office and say, "Doc, my wife is expecting a baby in December," or whenever they calculated the time of delivery. The wife was seldom seen until labor started, and then my father would take off for the patient's home. He would stay for a period of one to three days until it was accomplished. For this service my father received \$5.00. If cash was not available, he was paid in farm produce.

In 1911 the horseless carriage arrived at the Yocum home. The car was a Studebaker called a Flanders. A grand touring car, no doors, no battery, but a crank, carbide lights and tires of tissue-paper-thin rubber.

It has been told me by many townspeople that our car was the first in Owen County. The Sunday ritual was to take a ride in the car. One spring day when Paul was a lad he dropped a knife under the

wheel of the Flanders, resulting in a flat tire. This made our father very furious and Paul still feels his backside burning from the thrashing he got. One has never lived until he has ridden in the back seat of a touring car with the driver chewing tobacco. You can guess the results on a white linen suit.

Years passed. World War I came and my father wanted to be an Army surgeon, but my mother said "NO." She was pregnant. She asked God to give her a girl—a baby girl for her older age. On March 11, 1917, Richard and I were born. How perverse can nature be? Twin boys, when she ordered a girl!

I do not intend to digress about our young lives much, as this is a treatise on Dr. Boaz Yocum. It did seem he realized at age 56 that his life was a failure. He arrived at this conclusion because he had left out the most important ingredient—God!

So he joined the Baptist Church in Coal City, became a deacon and a real "Hard Shell" Baptist. I do not need to say that the drinking days were over—no cards, no dancing, no fun of any kind on the Yocum program.

My father had a firm belief that girls should not have an education. He was a great lodge member. He gave all 32 degrees in the Masonic Lodge. The Redmen and Odd Fellow orders were a part of his life. I always had the impression our family was rich, that they just hated Richard and me. Of course, this was not true.

To finalize this man's tribute, I must relate what he has contributed to humanity and the world. He retired in 1951, a medical doctor for 50 years plus, receiving an honorary dinner and certificate. His three sons are all medical doctors. His daughter finished college at the University of Oklahoma with an A.B. and earned a Master's degree in later life. Her two sons are doctors, Forest Orman is a surgeon in Lufkin, Texas, and Kenneth is an orthodontist in Corpus Christi.

Paul's oldest child is a doctor in Gary, an ophthalmologist. His son, Paul S. Yocum III, Boaz' great grandson, is now in his third year of medical school at Indianapolis.

There may be other medical contributions later from this man's humble start, but the last one at present is Susan Yocum, a nursing student at Wishard Memorial Hospital in Indianapolis, formerly Marion County General Hospital. She is the daughter of William S. and Edna Yocum.

They say a prophet is not without honor except in his own hometown. This, I think, is denied by the above account of the life of Dr. Boaz Yocum.

Death came in 1953, and he was buried at Beech Cemetery, among the people he loved.

(Submitted by the loving children, August 1975.)

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Further details may be obtained by writing to: S. Heyden, M.D., Department of Community Health Sciences, Duke University Medical Center, Durham, N.C. 27710.

"Surgical Technics—How I Do It" Title of Cleveland Clinic Course

The Cleveland Clinic will conduct a continuing medical education course on "Surgical Technics: How I Do It" on Jan. 14 and 15, 1976. The registration fee, which includes two luncheons and a reception, is \$100. Acceptances will be made

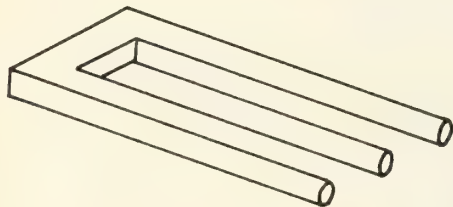
in order of application. Write to Cleveland Clinic Education Foundation, 9500 Euclid Ave., Cleveland, Ohio 44106.

Radiology Course at Aspen in March

The Sixth Annual Aspen Radiology Conference will be held from Mar. 1 to 5, 1976, at the Aspen Institute for Humanistic Studies, Aspen, Colorado. Advances in diagnostic radiology, nuclear medicine and radiation therapy will be discussed. Write to Emanuel Salzman, M.D., Beth Israel Hospital, Denver 80204.

Cancer Management Course in May

I.U. School of Medicine will conduct a course on "Current Concepts in Management of Gynecologic Cancer" May 20 and 21, 1976. Special interest to family practitioners, internists, Ob-Gyn specialists and radiation therapists. Latest detection and treatment methods will be covered. Several nationally known speakers will participate. ◀



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For more information about ovarian cancer dial 1-800-231-6970 and request tapes by number:

- #726 — DIAGNOSIS AND MANAGEMENT OF UNCOMMON TUMORS OF THE OVARY, Felix N. Rutledge, M.D.
- #732 .. MANAGEMENT OF COMPLICATIONS OF RADIATION THERAPY FOR PELVIC MALIGNANCIES, J. Taylor Wharton, M.D.
- #859—GYNECOLOGIC CHEMOTHERAPY, Julian P. Smith, M.D.
- #860 — OVARIAN CANCER, Julian P. Smith, M.D.
- #861 — CURRENT THERAPY IN GYNECOLOGIC SURGERY, Thomas C. Day, M.D.

DIAGNOSIS AND MANAGEMENT OF COMMON SKIN CANCER

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- COLONOSCOPY ...
- TESTICULAR CANCER ...

WILLIAM M. DUGAN, JR., M.D.
Vice-President, Indiana Division
American Cancer Society, Inc.

What's New?

The McGraw-Hill Company has released a new book by Dr. C. A. Tripp—"The Homosexual Matrix." The author, who is a psychologist and psychotherapist, provides fresh insights and provocative observations. Wardell Pomeroy, co-author of the Kinsey Report, says of it "a book destined to become a classic." Priced at \$10.

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Indications: Lomitol is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomitol until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomitol include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: **Lomitol is contraindicated in children less than 2 years old.** Use only Lomitol liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonsfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomitol liquid.

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When diarrhea has him reeling...



Diarrhea can hook anyone. When it does, physicians and patients both want prompt control of diarrheal symptoms. Lomotil will usually control diarrhea promptly.

This rapid action can halt the emergency aspect of diarrhea and is comforting and reassuring to the patient. Electrolyte and

fluid losses can be corrected while the specific cause of the diarrhea is being determined. If an infective agent is the cause, appropriate specific therapy should be given along with Lomotil.

Lomotil is contraindicated in children less than 2 years old.

Lomotil[®]

TABLETS, LIQUID

holds the line.

Each tablet and each 5 ml. of liquid contain: diphenoxylate hydrochloride 2.5 mg. (Warning: May be habit forming), atropine sulfate 0.025 mg

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association



The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

Opinion
&
Dialogue

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebotrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical
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- Can relieve nausea and vomiting often associated with vertigo.*
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- Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg/kg/day in rabbits and 10 mg/kg/day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patient should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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Antivert®/25 (meclizine HCl) 25 mg. Tablets for vertigo*

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Guest Editorial

**Incompatibility
or Desertion?**

*I*t would appear that there comes a time in the progress of any dynamic socioeconomic political system that certain parts (or a part) of that system reach a point of incompatibility with the remainder of the system. This is either because of that part's inability to change or because it has been deserted by the remainder of the system.

The medical care system of the United States has come under repeated condemnation by various segments of society because it allegedly fails to give the members of that society everything that they want at a price that is convenient for all. No one seriously contests the effectiveness of the system of medical care when it is related or compared to existing systems. It has never been accused of being Utopian; neither has it ever suffered the ignominy of being second best.

Perhaps all this criticism has the effect of making us more introspective and self-condemning than we have any right to be. However, there are others who are Darwinian disciples who would say that the system is better than it has any need to be. We even argue over whether an individual's medical care is a right or a privilege. We seem to choke on this bit of dessert while

we haven't even digested the main question and that involves an individual's medical needs as contrasted with his wants. Obviously there may be many systems of medical care that can solve the caring for a society's medical needs but not many come as close to providing for its wants as does the American medical system of care as we presently know it. This leaves its critics (and they are legion) with the considerable problem of how to improve on meeting a people's demands with a new and untried system when these same critics do not even know where the deficiencies are in the one system in the world, at least so far, that seems to be working reasonably well. But then, perhaps it is better to be criticized by ignorance than damned with faint praise.

And now, to add a bit of sauce to the whole potpourri, we are being inundated with legal criticisms via the malpractice crisis. Of course there is such a thing as malpractice, just as there is malfeasance of office in politics, embezzlement in banking and crooks in the legal profession (remember Watergate—there wasn't one physician indicted). However, most of the so-called malpractice suits are ludicrous attempts to obtain economic remuneration via emotion and ability to pay rather than on a determination of right and wrong. This is done to satisfy a sick society's appetite for

emotional restitution for "Acts of God" or just the normal experiences of living. We have a society that believes that someone owes somebody something if any misfortune befalls them. This is idiocy. No society is so wealthy that it can pay for "pain and suffering"; nor should anyone have to do so. This cancerous growth in our thinking has unfortunately been nurtured by an outdated legal system that cares little about right or wrong but places its emphasis on instructing those who have to give to those who have less. The American judicial system has become a quasi-welfare system mainly concerned with who can pay it and, secondly, who can pay its clients.

In our society we have a tort law system that seeks justice via intellectual mediocrity. The opposing barristers do not want learned people on the jury who might ask introspective and analytical questions that might lead to a solution based (heaven forbid) on right or wrong; rather, they want people who can be easily led by their emotional bleatings and can be led to decide by the more glib discussant. But then, whoever said that to decide on the basis of right and wrong was the basis of the adversary proceeding if the adversaries chose to debate the emotional content of a problem rather than its merits?

Since it seems to have been decided by the aid of the legal pro-

fession that the medical profession (directly or indirectly) should pay, we have reached an impasse in our social system.

It is no excuse but only a statement of fact that is known to all knowledgeable people (but few in the legal profession) that medicine is not a science. The human body does not always respond in a predictable way each time that something is done to it. The practice of medicine is made up of a dynamic set of variables and one must always try to be on guard to insure that that which occurs is a result that is desirable or, at the very least, if undesirable, correctable. However, there are many in the legal profession who would like to think of the practice of medicine as a test tube experiment in the chemistry laboratory. This is as stupid as trying to administer justice in a historical vacuum.

The conclusion to be ascertained from this rhetoric is that no professional group such as Medicine can remain viable in a society that is uncompromising in its views. Health care providers cannot provide Utopian results. They cannot and should not be expected to stand the test of perfection when viewed in retrospect. They must be permitted variability and they must not

be judged out of context. To restrain innovativeness is to stifle progress and that, in turn, assures mediocrity. What other profession is called upon to make so many judgments in a day's time without the benefit of slow and painful research? It is time for the medical profession to gather some backbone and say "Enough!" to a legal system that is archaic and costly. We should only allow ourselves to be judged on our ability to practice and to continue to practice by our peers and not by an emotionally charged group of people who forget right and wrong.

Therefore, I profoundly suggest that health care providers (during and for the performance of their duties only) be judged by themselves and remove themselves from the adversary system of judgment. Of course, criminal cases where one could show malicious intent would be cause for forfeiture of professional status and remanding to criminal proceedings. Also, let people insure themselves against "Acts of God," much as one does now when he (or she) buys flight insurance when taking a commercial plane trip.

Let us cease trying to play the role of saint—a role for which we are poorly equipped—while the lawyer plays the Devil's Advocate, a role for which he is perfectly suited.

It is impossible for us as a profession to get redress for our grievances from either of the two parties that have the most to gain by maintaining the status quo—the legal profession and the insurance industry. They will only change if we rebel. After all, as long as you can obtain gratification by rape and get away with it, why assume the responsibilities of marriage? Gentlemen, I assure you that until we (of the medical profession) make the crisis a profound one, we will continue to be raped.—**DeWayne L. Hull, M.D., 3030 Lake Avenue, Fort Wayne 46805**

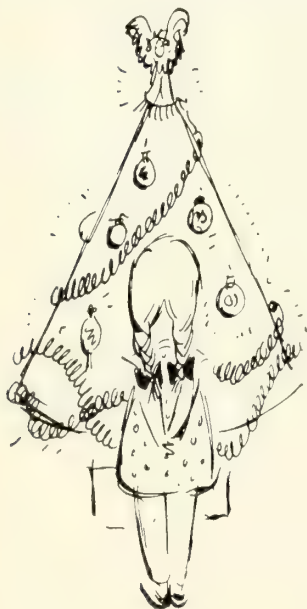
by two pharmacy professors urges greater use, by the physician, of the professional services of the prescription pharmacist. The fact that one third of all prescriptions are never filled and the further fact that only about half of those filled are completely consumed according to instructions emphasizes the importance of the pharmacists conjoint duties in counseling the patient on proper drug usage.

The Insurance Information Institute reports on public opinion polls on malpractice. Ninety percent of the public are aware of the problem, 70% blame the lawyers for the crisis, and the most favored solutions are (1) impartial arbitration panels, (2) an end to contingency fees and (3) a limit on jury awards. Sure sounds like the Indiana law.

Emergency medical products and services constitute a large business—now at the \$326 million level. The annual growth rate for the industry is predicted at between 5½% and 8% through 1984. Hospital purchases of new ambulances, communication nets and biomedical telemetry systems will head the list.

Almost \$1.5 million dollars worth of silver and mercury was recovered by the 171 VA hospitals last year. The agency sold 901,343 pounds of obsolete diagnostic x-ray film in 1974 and realized \$662,000 from this source. Recovery from exhausted x-ray developing solutions during the year produced an income of \$761,747. This type of salvage is important, not only from the financial viewpoint, but also for another practical reason. The current use of silver now exceeds the amount mined by a considerable amount. Until a photographic process which is not dependent on silver is invented, strict conservation of the supply is important.

Notre Dame's research grant from American Cancer Society will be devoted to "Enhancement of Chemotherapy Through the Use of



Editorial Notes . . .

An article in **HEALTH TEAM**

Liposomes. Anti-cancer chemicals will be enclosed in artificial envelopes consisting of liposomes. The theory is that enzymes, which ordinarily deplete anti-cancer chemicals will be prevented from doing so by the liposome covering, thus making the chemical more effective within the cell.

Children deserve protection in autos despite the fact that Model Safety Belts Usage Laws exclude small children. More than 1,000 children under five were killed and more than 77,000 were injured in auto accidents in 1972. *Pediatrics* in its August issue, notes that proper child restraint devices have proven effective and should be used.

Doctors who tend to work long and irregular hours don't know usually what "shift" they are working on. Sometimes it seems that "old doc" is on hand at least for some of

all three shifts. Someone in California is researching the question of which shift is the healthiest. They have spotted a plant with all three shifts actively working and will study the setup to determine which shift gets the most "ulcers." This is being done for the federal Department of Health, Education, and Welfare.

FDA regulations to assure equal therapeutic effect amongst various brands of drugs are twofold. They (1) require manufacturers to describe methods for determining bio-availability, and (2) set procedures for manufacturers to use in proving equivalence. Commissioner Schmidt has the effrontery to proclaim that this will assure the physician of dependability and uniform high quality.

Population in the U.S. increased by 0.76% in 1974, the fourth consecutive year in which annual rate

of growth was below 1%. The crude birth rate in 1974 and also in 1973 was the lowest level on record—15 per 1000 population. Health conditions were also at record levels in 1974—the crude death rate was 9.1 per 1000, an all-time low.

The public press still harps on the "high price of drugs." The PMA points out that the Bureau of Labor Statistics figures show that the "all items" index of the cost of living finished 1974 at 147.7. At the same time, the index for prescriptions stood at 102.9, almost the best bargain of any of the necessities of life. One author recently argued for abolishing the laws against product substitution by pointing out that a brand of ampicillin Pen-A cost the consumer \$4.19 for 20 capsules, while the generic forms usually cost \$4.44 and sometimes as high as \$7.85. ◀

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The Woman's Auxiliary Reports to ISMA

Dear Doctors,

"Merry Christmas"

First, the Auxiliary wishes to thank the ISMA for their vote of confidence in granting the Auxiliary support with the passage of Resolution No. 75-16.



This is the time of year to focus on the fact that no life work is really insignificant. It can be a channel through which a God-given love for others can flow. At a recent leadership confluence in Chicago we were made more aware of auxilian contributions, through the project bank. We were asked: "Which bank delivers you a whole world of volunteer knowledge?" The answer of course is: "We Do!" — When it comes to programs and projects we are there — our auxiliaries around the country, as well as other organizations and government — help us keep in touch with worthwhile efforts. It is the ultimate goal of all Auxiliary programs — filling identified needs. We start where we are with what we have. A brief program bank synopsis of subjects indicate the varied purpose and effect

of each project. Each state's **Project Bank Card Catalog** contains information in the following categories: Aging, Blood Donor, Children and Youth, Family Life, Fund Raising, Health Careers, Health Education, Screening, V.D., Miscellaneous, International Health, Mental Health, and Safety. In addition, the American Medical Association Auxiliary can provide package programs and resource listings in some of these and other categories. Many of Indiana's County Medical Auxiliaries have programs or projects in the **Project Bank Catalog** to share with others.

This holiday season may we continue to channel our love for others to improve the quality of life for all. In conclusion, I'd like to share an auxiliary collect with you.

Thank you, Father, for granting us another day.

As we share in our husbands' lives may we be understanding and kind, realizing that they have many burdens we cannot share.

Make us true companions and helpmates, and give us the joy that comes from service to others.

Amen

Sincerely,

A handwritten signature in cursive script that reads "Allie C. Reed".

Mrs. Edsel S. Reed
President
Indiana State Medical Auxiliary





BOOK REVIEWS

CARDIOVASCULAR DISEASE: EPIDEMIOLOGY, PREVENTION AND REHABILITATION. A GUIDE TO THE LITERATURE, VOL. 1: 1960-1973

Senta S. Rogers, Ph.D., and Irvin C. Mohler, M.A., IFI/Plenum, New York, 1975; \$49.50.

As new investigation must be built on previous work, the availability of a selected bibliography is of utmost importance to an investigator as new work is being planned, technics are being considered and significance is being assessed. While literature search capability is available via MEDLARS from 1964 on, one often receives more listings than are pertinent and material is unselected relative to any particular principal emphasis.

While the relative completeness of this book is unknown, it should provide ready access to pertinent literature in the areas of epidemiology, prevention and rehabilitation in coronary artery disease. By so doing, it would be a valuable asset for any investigator. Its usefulness can only be assessed through use, however.

There are some reservations about the indexing. Articles selected at random in the main body of the book are often difficult to find in the index. One, for example, on muscle metabolism during exercise cannot be found in the index under muscle, metabolism or exercise. Another on the effects of exercise on platelet adhesiveness is not indexed under platelet adhesiveness. It is indexed under platelets, however, and perhaps to ask for that much specificity is asking too much.

The volume is an attempt to ease a difficult problem. The impression is that it has been a good attempt.

SUZANNE B. KNOEBEL, M.D.
Indianapolis

IF YOU WANT TO BE A DOCTOR BUT DON'T HAVE THE MONEY—HERE'S HOW. An Autobiography of a Man Who Did It

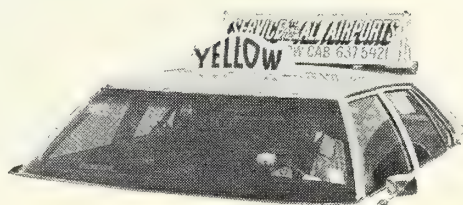
Roy Lee Smith, M.D., Exposition Press, Inc., New York, 1975; 48 pages; \$4.00.

Dr. Smith presents an interesting portrait of a poor but shrewd middle-class American boy of Protestant background who made it through medical school in the early years of this century and went on to an active life as one of the old-time Indianapolis urologists. The title of the book is something of a fraud, so don't actually expect to learn how to repeat the author's experience today. There are no necessary analogies here for the modern impecunious student except perhaps to emulate his quality of "pluck." His intellectual complacency can be dispensed with altogether.

What can the reviewer say of one who proudly recounts his inability to recognize the value of the transurethral prostatic resection when he had the opportunity to learn the procedure as head of a urology department of the U.S. Army in World War II; of one who writes boastfully of using penicillin (a new drug in the 1940s) by following a rote

Continued

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Where people come first

directive from the Army Medical Service and of being derided for this at a medical meeting; of one who thought an episode of impotency when he was in his 50s was due to exposure to x-rays; of one who . . . ? He certainly possesses the virtue of courage in good measure, although prudence seems not his long suit—especially in setting pen to paper.

On the positive side, I believe from reading this book that Dr. Smith is unquestionably a morally straight human being.

RODNEY A. MANNION, M.D.
LaPorte

THE CURRENT STATUS OF CARDIAC SURGERY

Edited by D. B. Longmore, F.R.C.S., L.R.C.S., M.B., University Park Press, Baltimore, 1975; 500 pages with numerous diagrams and tables plus an excellent bibliography. MTP (Medical and Technical Publishing Co., Limited); \$39.50.

After having become accustomed over the decades to toiling and moiling reading complex essays on various complex medical problems, it is absolutely delightful to come across a volume that reduces complex terminology to the sophomore medical student level: and that without detracting in any way from the clear exposition of the topics: A whole pride of experts drawn from all over the world present the reader with the essence of their topics in clear, concise and lucid detail: "Cardiac Transplantation," "Fallot's Tetralogy," "Prosthetic Valves," "Tissue Valve Replacement and Repair," "Open Heart Surgery Under One Year of Age," "Ischemic Heart Disease," etc.

This volume has to be read and reread to be truly savored and appreciated. The paper, binding and typing are up to the

publisher's usual high standards. But **all** hospital and medical libraries will be buying this volume at its relatively modest price. Most M.D.s would appreciate a copy for a Christmas or what-have-you present. Congratulations all around!

ARNOLD LIEBERMAN, M.D.
New York City

SENSORY CAPABILITIES OF HEARING-IMPAIRED CHILDREN

Edited by Rachel Stark, Ph.D., from Department of Otolaryngology, Johns Hopkins University School of Medicine. University Park Press, Baltimore, 1974; 244 pages; some illustrations and diagrams; \$9.75.

This modestly priced, compactly and lucidly written and very well put together monograph should become but immediately **MUST** reading for teachers of retarded children! When do we discover that their real problem is "just" deafness? And—don't forget: Hearing defects vary from total to just partial!

While aimed at the teachers at the special schools, most M.D.s would do well to read this volume, chapter by chapter, when they have the time between more pressing chores. I know I savored it after supper and at bedtime. The writing is simple and most instructive. I recommend particularly chapter 11, where Dr. Stark writes on "Looking to the Future: Overview and Preview." Sensory Capabilities, Perceptual and Cognitive Strategies and Language Processing—all become not merely phrases but actual concepts aiding us in handling the handicapped. Kudos to Dr. Stark and her co-workers!

ARNOLD LIEBERMAN, M.D.
New York City

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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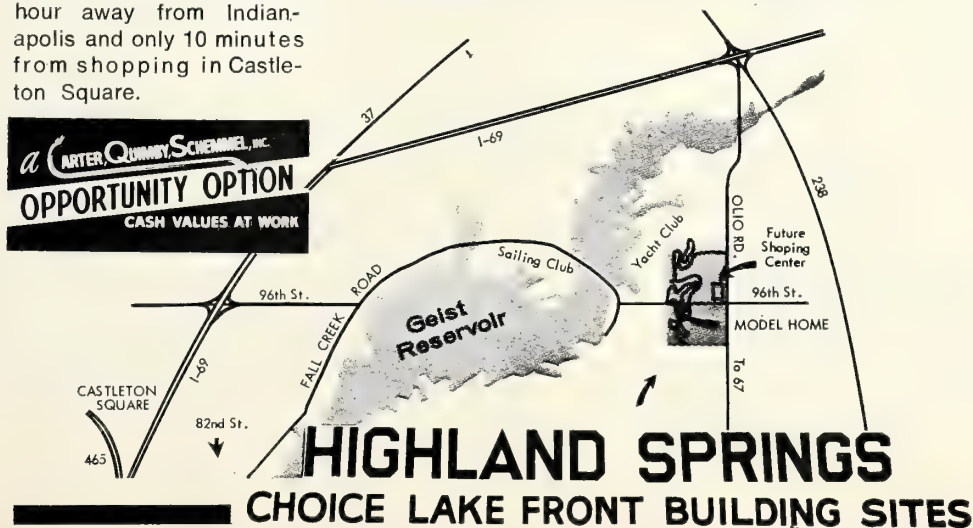
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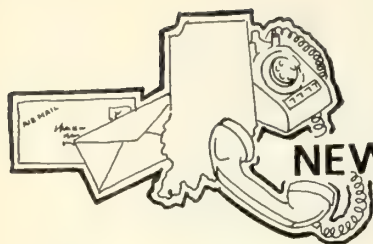
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NEWS NOTES

Muncie Center Dedicated

Dr. Steven C. Beering, dean of the Indiana University School of Medicine, was one of the speakers at the dedication and official opening of the Muncie Center for Medical Education, where medical students take their first and/or fourth year of medical school. The second floor of Ball Hospital's Maria Bingham Hall, formerly a nurses' residence, was remodeled into classroom, laboratory and office space for the Muncie program.

Tribute was paid to "**Drs. Thomas Moore, Lall Montgomery, Ross Egger** and the late **Dr. Gene Stout** who, . . . worked a decade ago to get a medical school in Muncie."

Dr. Fisch Lectures in Far East

Dr. Charles Fisch, Indianapolis, director of the Krannert Institute of Cardiology and president of the American College of Cardiology, was one of four American doctors who lectured Oct. 27-Nov. 11 in the Philippines, Burma and Pakistan. The lecture tour was sponsored by the American College of Cardiology and the U. S. State Department.

Dr. Davis Named to Board of Regents

Dr. Joseph B. Davis, Marion, has been appointed to the Board of Regents of the American College of Surgeons. He formerly was governor of the College.

Named Porter County Board Chairman

Dr. Gary Babcoke, Chesterton, has been elected chairman of the Porter County Health Department Board.

Retires as Executive, Becomes Director

Dr. Byron L. Steger, Indianapolis, who retired recently as executive vice-president of Winona Memorial Hospital, has been named to the hospital's Board of Directors. Dr. Steger retired with the rank of Major General in the U.S. Army and became director of the hospital in 1971. He and Mrs. Steger plan to continue to make their home in Marion County.

Dr. Paris Named to IUS Board

Dr. John Paris, New Albany, has been appointed to the board of advisors for Indiana University Southeast. The advisory board meets several times a year with the IUS Chancellor and offers recommendations to the Indiana University Board of Trustees.

Hoosiers Serve on AMA Committees

At the October meeting of the Board of Trustees of the American Medical Association **Dr. Don Wood**, Indianapolis, was reappointed chairman of the Committee on Insurance.

Two Hoosier physicians served on reference committees at the Clinical Convention in Honolulu. **Dr. Malcolm O. Scamhorn**, Pittsboro, served as chairman of Reference Committee F, and **Dr. John Butler**, Indianapolis, was a member of Reference Committee H.

Lutheran Hospital Holds Staff Election

Dr. Alan D. Richards has been named president of the Lutheran Hospital (Fort Wayne) Medical Staff for 1975-76. He succeeds **Dr. Allen W. Aldred**.

Other officers are **Drs. Don E. Miller**, president-elect, **Dean D. Dauscher**, secretary, and **James E. Buchholz**, treasurer. Serving with Drs. Aldred, Miller and Richards on the Executive Committee will be **Drs. Joseph R. Hoover, Richard E. Bower** and **James S. Hill**.

Dr. Sigmund Continues as Health Officer

Dr. William B. Sigmund, Columbus urologist, has closed his office and retired from private practice but will continue to serve as the Bartholomew County Health Officer.

Name Changed to Wishard Hospital

At the recent ceremonies dedicating the Regenstrief Health Center it was announced that Marion County General Hospital was henceforth to be known as Wishard Memorial Hospital, memorializing **Dr. William Niles Wishard**, the hospital's superintendent from 1879 to 1887. Founder of the American Board of Urology, Dr. Wishard was the first physician in Indiana to make genitourinary surgery an exclusive specialty.

The \$13 million, six-story Regenstrief Center is the outpatient clinic of Wishard Memorial Hospital. The facility, which the I. U. School of Medicine will manage along with the 109-year-old hospital, also houses the Regenstrief Institute, a separate entity devoted to research.

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Health Boards Elect Officers

The LaPorte County Board of Health elected **Dr. King S. Jones, Michigan City**, chairman for 1976, with **Dr. Barbara Backer, LaPorte**, vice-chairman.

Dr. Alfred E. Hollenberg, Hagerstown, is the new chairman of the Wayne County Health Board. **Dr. Francis B. Warrick**, county health officer, serves as board secretary. Other board members are **Drs. Raymond A. Weitemier and Richard Siebert**.

Dr. Nasser "Distinguished Alumnus"

Dr. William K. Nasser, Indianapolis, was one of five Indiana State University graduates named for the 1975 Distinguished Alumni Awards. He is director of the Cardiac Catheterization Laboratory at St. Vincent Hospital, Indianapolis.

Speaks on "Medical Experimentation"

Dr. Iver Small, Indianapolis, assistant superintendent of LaRue Carter Memorial Hospital, spoke on "Medical Experimentation" and participated in a panel discussion at Indiana-Purdue University, Fort Wayne, recently.

Scottish Rite Honors Dr. Province

Because of "outstanding contributions to Freemasonry or significant service to others reflecting credit on the fraternity," **Dr. William D. Province, Franklin**, was awarded the 33rd Masonic degree at the recent meeting of the Supreme Council of Scottish Rite Freemasonry for the Northern Masonic Jurisdiction, Boston.

College of Surgeons Names Fellows

Among Indiana physicians initiated into Fellowship in the American College of Surgeons at its meeting in San Francisco in October were **Drs. John W. Beaven, Jasper; Martin J. Bender, Evansville; Thomas Coulton, Muncie; Oscar G. De La Paz, Merrillville; Richard J. Houck, Michigan City; Bernard P. Kemker, Jasper, and Ben W. Woodward, Evansville**.

Gary Methodist Medical Staff Elects

Dr. Ernest Mirich has been elected president of the medical staff of Gary Methodist Hospital, succeeding **Dr. James Hadey**.

Other new officers are **Dr. R. J. Bills**, president-elect; **Dr. Raffy Hovanessian**, secretary, and **Dr. Sydney Choslovsky**.

Elected for three-year terms as chiefs of hospital divisions were **Dr. John Scully**, division of medicine; **Dr. Armand Fadul**, division of family practice; **Dr. Douge Barthelemy**, division of pediatrics; **Dr. George J. Volan**, division of surgery, and **Dr. C. W. Boone**, division of obstetrics and gynecology.

Dr. John Greist Heads Foundation

Dr. John H. Greist, Indianapolis, has been elected president of the Mental Health Association Memorial Foundation of Indiana.

Missouri Making Progress

The Governor of Missouri, Christopher Bond, reports steady progress in his state relative to ambulance service and emergency medical services. In 1972 only 40% of the population was covered by adequate ambulance service. Now 75% of all Missourians are covered and by 1976 more than 80% will be. Emergency medical services includes two-way radio communication between ambulances and more than half of the licensed hospitals.

Hoosier Physicians Elected by New College of International Physicians

The American College of International Physicians was recently organized. Membership is limited to practicing physicians educated in medical schools outside the United States. It is devoted to continuing advancement in education and medical skills. **Dr. Antonio B. Donesa, Fort Wayne**, is president; **Dr. Hanus J. Grosz, Indianapolis**, is president-elect; **Dr. J. Wei Ping Loh, Gary**, is secretary, and **Dr. Jose H. Tord, Indianapolis**, is treasurer.

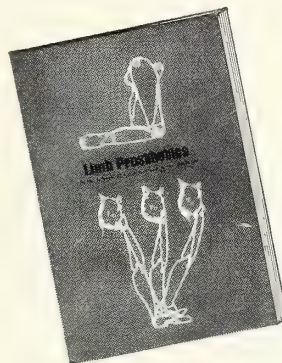
Offer Hospital Fire Safety Film

The National Fire Protection Association has a new color film which explores ways to implement and maintain a fire safety program in hospitals. Hospital fires have increased in frequency by 100% in the past five years. Fire loss in dollars has increased by 140%. Title of the film, which has a running time of 21 minutes, is "Reasons for Caring." Available in 16 mm and video cassette. May be ordered for \$265 from NFPA, 470 Atlantic Ave., Boston 02210.

Squibb Offers New Film

"Procainamide in the Management of Acute Ventricular Arrhythmias" is the subject of a new educational film by courtesy of E. R. Squibb & Sons. It is available as a 16 mm film or U-matic ¾ inch videotape. The 30-minute, color film is available without charge for use by medical groups by writing Squibb at P.O. Box 4000, Princeton, N.J. 08540.

Continued



HANGER PROSTHESES OFFERS BOOKLET ON AMPUTATIONS

This booklet has been designed for those physicians whose practice includes amputation. **Limb Prosthetics** gives ready reference for each site of amputation as well as the prostheses recommended for each site.

Over 100 years of experience gained by the Hanger organization have gone into this carefully illustrated booklet. Illustrations include amputation sites for the leg and the arm, various Hanger prostheses and methods of suspension, post-operative care and preparation for prosthesis, plus selected photographs showing the child amputee and training for the above-knee patient.

We believe that you will find **Limb Prosthetics** a most useful booklet and a valuable source of quick information. To obtain your copy, please write or phone the Hanger office nearest you.

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PMA Announces Six \$5,000 Grants

The Pharmaceutical Manufacturers Association Foundation announces plans to award its Medical Student Research Fellowship grants for the academic year beginning July 1, 1976. Each of the six grants of \$5,000 will go to a medical student who plans to pursue a career in pharmacology-clinical pharmacology and who will devote a year full-time to a specific research effort in these fields. The deadline for applications is Jan. 15, 1976.

Medical Education Fair Held at Muncie

An "Education Fair," devoted to discussion of continuing education of physicians and paramedical persons was held recently at the Ball Memorial Hospital, Muncie. The Indiana Academy of Family Practice and the Family Practice Residency Department of Ball Hospital sponsored the meeting and Merck Sharp & Dohme provided financial assistance. The major topic of discussion was the role of hospital administration in continuing education. The meeting may lead to the formation of a Council of Medical Education. The program will probably be repeated next year.

Erratum

The name of the Lafayette Medical Education Foundation was incorrectly listed as Lafayette Medical Foundation in the published Supplemental Report of the Commission on Medical Education and Licensure, page 904, October issue.

Biweekly Review on Clinical Neurology

The Clinical Neurology Information Center publishes a bi-weekly review of articles of interest to clinical neuroscientists (neurologist, neurosurgeon, neuropathologist, speech pathologist, etc.). The review includes articles published in more than 850 regularly recurring journals. Annual subscription price is \$15. The address is University of Nebraska Medical Center, 42nd and Dewey Ave., Omaha, Neb. 68105.

C.E. Program on Thyroid Function

Ames has a new continuing education program on thyroid function. It consists of a half-hour film and a Monograph/Workbook. It is available without charge and is free of references to commercial products. Address Dept. TH, Ames Company, Elkhart, Indiana, 46514.

Fire Protection Book Offered

The National Fire Protection Association has a new book "Emergency Medical Services for Fire Departments" which sells for \$7.00.

Attend Cardiology Conference in Mexico

Dr. and Mrs. Elmer R. Billings of Elkhart have returned from a special conference on cardiology in Cancun, Mexico. Seventy physicians from 11 states met Oct. 10 to 14 to hear four distinguished cardiologists discuss coronary artery disease.

From *The Journal* 50 Years Ago

The gall-bladder has been a surgical trophy since 1882, but its functions still are shrouded in mystery and the pathogenesis of its diseases is the subject of dispute. Some surgeons regard the gall-bladder as a mere purposeless *cul-de-sac* that still develops from the anlage which forms the liver and the bile ducts. Others, like Rovsing, esteem it as a highly useful organ. The truth probably lies between these two extremes. . . .

The gall-bladder contains no glands, except possibly a few in the neck, and it adds nothing to the bile except mucus. It is not a reservoir like the urinary bladder — its small size, its fixed position in its bed in the liver, and the structure of its mucosa render such an idea untenable. W. J. Mayo remarked in 1911 that no one had ever seen the gall-bladder contract.

Infection alone does not produce stone, but it does produce the non-calculous varieties of cholecystitis which embrace almost 30% of benign gall-bladder lesions. Gallstone disease is actually a distinct condition. Infection is not a factor in the production of cholesterol stones (Aschoff), but it plays some imperfectly understood role in the causation of the mixed stones. A hyperactivity of the concentrating power of the gall-bladder and some metabolic disturbance resulting in a richness of the cholesterol content of the bile or to its ready precipitation are the most important factors in stone formation. As Charles Mayo points out, we are back again to humoral theory. We cannot make light of the importance of biliary stasis in stone production as Continental writers regard it as an essential feature. . . .

I have no desire to enter the dispute of "Cholecystectomy vs. Cholecystotomy." Personally I remove the gall-bladder except when the removal adds materially to the risk or when there are symptoms of common duct obstruction. I am willing to have each surgeon choose his operative procedure after a study of his own case histories. I do insist, however, that tinkering with a gall-bladder for a non-calculous cholecystitis almost always results in evil. . . . "Gall Bladder Disease," H. O. Bruggeman, M.D., Fort Wayne, *JISMA*, December 1925.

Association News

EXECUTIVE COMMITTEE

Sept. 20, 1975

The meeting was called to order at 3 p.m. at the Headquarters Building by Chairman Thatcher. Roll call showed the following present: William R. Clark, member; Eli Goodman, member; Gilbert M. Wilhelmus, president; Vincent J. Santare, president-elect; Richard G. Ingram, chairman of the Board; Joe Dukes, immediate past president; Hugh K. Thatcher, Jr., treasurer; Arvine G. Popplewell, assistant treasurer; Frank B. Ramsey, Editor *The Journal*; James A. Waggener, executive secretary and Kenneth W. Bush, administrative assistant.

Guest: Stuart A. Kleit, Department of Urology, Indiana University School of Medicine.

MINUTES OF THE MEETING HELD AUG. 6, 1975, were approved by consent.

MEMBERSHIP REPORT was reviewed and approved.

A LETTER FROM DEPARTMENT OF DEFENSE APPROVING THE EXPENSE of moving the CHAMPUS department was read and, by consent, the secretary is instructed to proceed.

RENEWAL OF CONTRACT FOR A PERIOD OF TWO YEARS FOR CHAMPUS PROGRAM was approved for signature by the President upon motion of Dr. Santare and a second by Dr. Clark.

The secretary reported it would be necessary under the zoning law to provide parking space at 3942 N. Pennsylvania St. for at least 10 cars at a cost of approximately \$4,000. The secretary is authorized to proceed and action was approved by consent.

A STATEMENT FROM A MEMBER OF THE SPEAKER'S BUREAU was reviewed and discussed and the matter was deferred until the next meeting. The secretary reported on the increase in telephone rates. This was taken as a matter of information.

LETTER FROM CONTINENTAL COLLECTION BUREAU. Upon motion of Dr. Dukes and a second by Dr. Clark, the Association will not participate in this program.

LETTER FROM TEXAS MEDICAL ASSOCIATION regarding constitutional opinion on Professional Liability was taken as a matter of information.

REQUEST OF DR. PAUL MULLER was reviewed and, upon motion of Dr. Santare and a second by Dr. Goodman,

the committee approved the request with the stipulation that this was sent to him for his personal use only.

LETTER FROM THE INDIANA ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS announcing its participation in the expense of preparation of H.B. 1460 was taken as a matter of information.

LETTER FROM CAYLOR-NICKEL CLINIC requesting use of the mailing list was approved upon motion of Dr. Clark and a second by Dr. Santare.

REQUEST OF THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY was approved upon motion of President Wilhelmus and a second by Dr. Santare.

LETTER FROM A. FRANKLIN WHITE, M.D., Louisville, for use of the mailing list. Upon motion of Dr. Dukes and a second by Dr. Goodman, the request was approved providing that this man is first investigated and checked out.

LETTER FROM METHODIST HOSPITAL, Indianapolis, requesting use of mailing list was approved by Dr. Santare and a second by Dr. Goodman.

DR. STUART A. KLEIT appeared before the committee and explained the plans for developing a network of renal dialysis facilities and, following a discussion, upon motion of Dr. Santare and a second by President Wilhelmus, it was voted that this be referred to the Board of Trustees with the recommendation that ISMA participate in the program.

INTERMEDIARY LETTER NO. 75-17 DEALING WITH MEDICARE FEE SCREENS for 1976 was reviewed for information of the committee and a memorandum from Blue Shield protesting this system was also reviewed and, upon motion of Dr. Dukes and a second by Dr. Goodman, the Association is also to add a protest.

Upon motion of President Wilhelmus and a second by Dr. Goodman, the secretary is instructed to prepare a resolution for consideration by the Indiana House of Delegates, calling on the AMA to file suit on these regulations.

LETTER FROM GOVERNOR BOWEN was read for information of the committee.

LETTER FROM DR. WILLIAM PAYNTER CONCERNING THE PROPOSED PROGRAM FOR TRAINING MEDICAL DIRECTORS of skilled nursing facilities and, by consent, the secretary is to instruct Dr. Paynter that ISMA would cooperate with such a program.

LETTER FROM AMA CONCERNING WORKSHOPS FOR NEW MEMBERS planning to enter private practice was reviewed and, upon motion of Dr. Dukes

and taken by consent, the secretary is to inform the AMA that such a program will be held during the 1976 annual convention of ISMA.

LETTER FROM DR. JOHN J. COURRY OF MICHIGAN was reviewed and action was deferred until next meeting of the committee.

REPORT OF AAMSE ADVISORY COMMITTEE to the executive vice president was reviewed for the information of the committee.

LETTER FROM AMA URGING PARTICIPATION IN THE AMA ORGANIZATIONAL STUDY was reviewed and taken as a matter of information.

CORRESPONDENCE BETWEEN THE SECRETARY AND DR. WILLIAM T. PAYNTER regarding physician participation at the state level on the Health Service Areas (HSA) program was reviewed and taken as a matter of information.

LETTER FROM AN INDIANA PHYSICIAN RAISING SOME ETHICAL QUESTIONS was reviewed and, by consent, this is to be referred to the Judicial Council of the AMA.

A LETTER FROM THE UNIVERSITY OF VIRGINIA MEDICAL SCHOOL was reviewed and taken as a matter of information.

A LETTER FROM THE AMERICAN ACADEMY OF PEDIATRICS was reviewed and taken as a matter of information.

A QUOTE IN THE GROUP PRACTICE NEWS LETTER was read and taken as a matter of information.

UTILIZATION REVIEW POLICY OF LOUISIANA STATE MEDICAL ASSOCIATION was reviewed and, upon motion of Dr. Dukes and a second by Dr. Santare, this is to be referred to the Commission on Governmental Medical Services.

A LETTER FROM CNA INVITING THE BOARD PROFESSIONAL LIABILITY COMMITTEE to meet in their offices on Oct. 8 was reviewed and the secretary was instructed to see if the time could be changed from 11 a.m. to 9:30 or 10 a.m.

THE MINUTES OF THE MEETING OF THE ADVISORY GROUP TO RMP was reviewed for the information of the committee.

CORRESPONDENCE BETWEEN A PHYSICIAN AND THE INSURANCE COMMISSIONER was reviewed for the information of the committee.

The secretary presented a proposal from Mr. Robert Mahowald to serve as a lob-

byist during the 1976 session; this was reviewed and President Wilhelmus and the secretary are to discuss this with our lawyers.

A REQUEST FROM THE COMMISSION ON CONVENTION ARRANGEMENTS for \$250 for the sporting events during the convention was approved upon motion of President Wilhelmus and a second by Dr. Santare.

REQUEST FROM THE COMMISSION ON PUBLIC INFORMATION to invite the members of the Speaker's Bureau to attend the annual meeting. The request was approved by consent with the understanding they would be attending at their own expense.

The secretary then discussed the proposed expenses of the Board Dinner and he was instructed to determine what would be the cost for the Singing Doctors for entertainment and also if a dinner wine could be served.

The secretary presented a letter from the State Medical Society Journal Advertising Bureau concerning a conference

to be held in Chicago on Sept. 23-24. Upon motion of Dr. Dukes and a second by Dr. Clark, Mr. Waggener and Mrs. Richardson were authorized to attend.

A LETTER FROM THE AUXILIARY REQUESTING A CONTRIBUTION OF \$1,000 was read and, upon motion of President Wilhelmus and taken by consent, they are to be sent \$200 at the present time with an explanation that if the resolution before the House of Delegates calling for \$1.00 contribution per member of the Auxiliary is not adopted, the balance of \$800 will be forthcoming.

A LETTER FROM PSI (Planned Security Inc.) was reviewed and the material is to be duplicated and sent to the members of the committee.

Upon motion of Dr. Goodman and a second by Dr. Santare, the president was authorized to invite Mr. Guthrie to attend meetings of the Study Committee created by passage of H.B. 1460.

Dr. Ingram informed the committee he had the personnel policies in rough and

would ask the secretary to duplicate these and distribute to the committee for their review and critique.

Notice from AMA concerning CONGRESS ON OCCUPATIONAL HEALTH to be held in Cincinnati on September 29 and 30. No representative is to be sent.

REGIONAL HEALTH INSURANCE MEETING in Chicago to be held Oct. 17-18. No representative will be sent.

A notice of the 28th ANNUAL MEETING OF THE AMERICAN ASSOCIATION OF BLOOD BANKS in Chicago, Nov. 9-14. No representative will be sent.

Upon motion of President Wilhelmus and a second by Dr. Ingram, Dr. Dukes was authorized to attend the meeting in Las Vegas at his own expense.

There being no further business, the meeting adjourned to meet again at 10 a.m., Sun., Oct. 19, 1975, in the French Lick-Sheraton Hotel, French Lick, Indiana.



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The 1975 Convention Story



INDIANA UNIVERSITY'S basketball coach Bobby Knight was one of the featured speakers at Tuesday's Sports and Medicine program—acclaimed as one of the best ever presented at an ISMA convention.

AMA PRESIDENT-ELECT Dr. Richard E. Palmer, Alexandria, Va., joined ISMA past presidents for their annual photograph. Seated (l. to r.) are Drs. Patrick J. V. Corcoran, Evansville; Palmer; Herman M. Baker, Evansville; Joe Dukes, Dugger; Eugene S. Rifner, Van Buren. Standing are Drs. Malcolm O. Scamahorn, Pittsboro; Lowell Steen, Hammond; Joe Black, Seymour; Guy Owsley, Hartford City, and Peter R. Petrich, Attica.





"BUSINESS AS USUAL" was the theme of the breakfast sessions of the Board of Trustees.



GOVERNOR OTIS R. BOWEN, M.D., addressed the House of Delegates on Monday.





DR. JOHN W. BEELER, INDIANAPOLIS, presided as speaker of the House. Later, following the election, he became president-elect. Shown with him are President **Gilbert Wilhelmus**; President-Elect **Vincent Santare** and Parliamentarian **Lester Hoyt**.

MEMBERS of the House of Delegates were giving all their attention to the speaker when the photographer happened along. (Below and opposite page.)





REFERENCE COMMITTEE No. 2, chaired by Dr. C. David Ryan, Columbus, worked hard at resolving the matters on their agenda.

DR. FRED W. DAHLING, New Haven, presided over the deliberations of Reference Committee No. 4, shown here hard at work.





DR. BRAD BOMBA, Bloomington, registered for the Convention while **Dr. Patrick J. V. Corcoran**, Evansville, waited his turn.

PRESIDENT GILBERT WILHELMUS (right) introduced **President-Elect Vincent J. Santare** to the guests at the Monday night dinner.



AT THE HEAD TABLE (left to right) at Monday night's dinner: **President Gilbert Wilhelmus**; guest speaker **Mr. David Hoy**; **Past President Joe Dukes**; **Treasurer Hugh K. Thatcher, Jr.**; **Mr. James A. Waggener**, executive secretary; and **General Convention Chairman W. Thomas Spain**, Newburgh.





IN THE RECEIVING LINE preceding the President's Dinner on Tuesday night were: Mrs. Edsel T. Reed, Jeffersonville, Auxiliary president; Miss Vicki Wilhelmus, Mrs. Wilhelmus, and Dr. Wilhelmus.

AN INNOVATION at this year's Convention was the 7-Mile Run, participated in by a number of members. The winners names appear on page 1054.



Convention Election Results

Dr. John Beeler Named President-Elect

Dr. John W. Beeler, Indianapolis, was elected president-elect of the Indiana State Medical Association at the closing session of the House of Delegates in October. He succeeds Dr. Vincent J. Santare, Munster, who was installed as president on Oct. 22.

(An account of the career and service to organized medicine of Dr. Santare appeared in the November *Journal*.)

Dr. Arvine G. Popplewell, Indianapolis, was elected treasurer, and Dr. Joseph F. Ferrara, Franklin, and named assistant treasurer.

Dr. Eli Goodman, Charlestown, was

elected chairman of the Board of Trustees, while Dr. Joe Dukes, Dugger, who served as president in 1974, was elected chairman of the Executive Committee. A new member elected to the Executive Committee is Dr. Richard G. Ingram, Montpelier.

Dr. William R. Cast, Fort Wayne, was elected speaker of the House of Delegates and Dr. Lloyd L. Hill, Peru, was chosen vice-speaker of the House.

New trustees chosen for three-year terms by their districts are: Dr. John G. Pantzer, Indianapolis, District 7, and Dr. Jack M. Walker, Muncie, District 8.

Drs. Paul W. Holtzman, Bloomington, District 3, Cleon M. Schauwecker, Greencastle, and James A. Harshman, Kokomo, District 11, were reelected to three-year terms on the Board of Trustees.

The only new alternate trustee is Dr. Paul F. Muller, Indianapolis, who was elected to a three-year term representing the Seventh District.

Drs. Glen Ward Lee, Richmond, and Leonard W. Neal, Munster, were reelected to three-year terms as alternate trustees, representing the Sixth and Tenth Districts, respectively.

Pressing National Issues Theme of AMA Conference

THE fourth annual Leadership Conference of the American Medical Association will be held Thursday, Jan. 22, through noon Sunday, Jan. 25, 1976, at Chicago's Marriott Motor Hotel located next to Chicago's O'Hare Field Airport.

Invitations are extended to elected officials of state, county and specialty societies and their executives, AMA officers, the AMA Board of Trustees and senior AMA staff.

According to James H. Sammons, M.D., executive vice president of the AMA, the program will focus on "the most pressing national issues facing the Federation."

In his invitation Dr. Sammons said, "As leaders you are the individuals who are being looked to for guidance and solutions to the diverse problems challenging the profession. The National Leadership Conference will provide you with decision-making information essential to your constituency."

Among the general subjects to be discussed at the conference are the National Health Planning and Resources Development Act of 1974, National Legislative Update, The Professional Liability Emergency—1976 and Beyond, Bringing the

Medical Society to the Member, Utilization of the AMA Center for Development and Research as a Data Clearinghouse for State Licensing Boards, and Meeting Our Challenges Head-on.

Registration fee for the conference is \$75, which includes informational materials and all formal meal functions at the Marriott.

Members of the ISMA Executive Committee and the Board are planning to attend this important conference, and county society officers and executives are also encouraged to attend.

THE WINNERS—126th Annual Convention

French Lick, Oct. 20-22, 1975

PHYSICIANS COMMUNITY SERVICE AWARD

This award, through the courtesy of the A. H. Robins Pharmaceutical Company, goes to an Indiana physician for "service to the local or state community which benefits them in a civic, cultural or general economic sense, and is entirely separate from purely professional achievement."

Dr. James H. Daggy, Richmond, was cited for his 20 years of service to the Boy Scouts, the Richmond Boys Club, the YMCA and other community projects, as well as giving statewide leadership to Scouting and the Hoosier Area Council, Boys Clubs of America.

ART AND HOBBY SHOW

Best of Show—Oil Painting—Mrs. Brad Bomba, Bloomington

Water Color Painting—W. P. Loh, M.D., Gary
Photograph—Black and White—Robert E. Hanne-
mann, M.D., Lafayette; H. Charles Smith, M.D., Bluffton

Oil Painting—Dan W. Hibner, M.D., Richmond; Ray
H. Burnikel, M.D., Evansville; Mrs. James L. Higgins,
Evansville; John L. Shively, M.D., Lafayette

Photograph—Color—H. Charles Smith, M.D., Bluff-
ton; David E. Sherman, M.D., Lafayette; Palmer O.
Eicher, M.D., Indianapolis

Sculpture—Mrs. Patrick J. V. Corcoran, Evansville
Crafts—Charles X. McCalla, M.D., Paoli; David Had-
ley, M.D., Plainfield

Special Exhibit—Mrs. James L. Higgins, Evansville



SCIENTIFIC EXHIBIT AWARD WINNERS

Awards for the excellence of the Scientific Exhibits at the 126th Annual Meeting were made to:

First place—Cardiovascular Surgeons, Inc., Indianapo-
lis—The Effect of Coronary Artery Surgery on Survival

Second place—Carl H. Linge, M.D., and William E.
Adamson, M.D., Evansville—Aspiration Needle Lung
Biopsy

Third place—G. T. Chua, M.D., Beech Grove—Gray
Scale Ultrasound Laminography

JOURNALISM AWARDS

At the President's Dinner on Oct. 21 the annual
journalism awards were presented to the following:

Television—Mac Heald, reporter for WLWI-13, Indi-
anapolis, for his 30-minute documentary "My Baby Is
Critically ill."

Newspapers—Mike Pomper, a staff writer for the
Michigan City **News-Dispatch**, for his five-part series on
the medical liability crisis facing physicians in Indiana.

Radio—Millie Pilot, Merrillville, commentator for
Radio Station WJOB, Hammond, for the continuing ex-
cellence of her coverage of health and medical matters.

GOLF TOURNEY WINNERS

Men

David S. Chamberlain, South Bend; B. V. Roberto,
Austin; William R. Thompson, Winamac; Antolin M.
Montecillo, Clinton; Donald G. Mason, Angola
High Net, Men—Thomas C. Tyrrell, Hammond

Women

Mary Lou Evans, Valparaiso
High Net, Women—Kay Mason, Angola

TENNIS TOURNEY WINNERS

Men's Singles

Winner—Roger Barnard; Runner-up—Daniel R. Evans,
Valparaiso

Women's Singles

Winner—Mollie Harris, Goshen; Runner-up—Cathy
Siderys, Indianapolis

Mixed Doubles

Dr. and Mrs. Daniel R. Evans, Valparaiso

SEVEN-MILE RUN

Charles E. Hansell, Fort Wayne; William A. Abell,
Anderson; Herbert C. Ufkes, North Judson; Howard J.
Henry, Knox

Minutes of the House of Delegates

1975

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House of Delegates Proceedings

October 20 and 22, 1975

FRENCH LICK SESSION

The first meeting of the House of Delegates was called to order at 9:25 a.m., EST, Mon., Oct. 20, by President Gilbert M. Wilhelmus in the Convention Hall of the French Lick-Sheraton Hotel, French Lick.

The final meeting of the House was convened at 9:00 a.m., EST, Wed., Oct. 22, in the Convention Hall of the French Lick Sheraton Hotel.

Invocation was given by Dr. Malcolm O. Scamahorn, Pittsboro.

In Memoriam

Following is a list of members of the Indiana State Medical Association who were members of the House of Delegates or who served the Association in an official capacity and who have died since the 1975 annual session.

ROBERT M. ACRE, Evansville
PETER J. BIRMINGHAM,

South Bend

DON F. CAMERON, Angola
PAUL A. CLOUSE, Evansville
WENFRED J. FUSON, Greencastle
OSCAR D. HAVENS, Cicero
LESTER H. HOPKINS, Versailles
NATHANIEL C. ISLER,

Jeffersonville

GEORGE E. ITERMAN,
New Castle

CHARLES A. JONES, Franklin
ORVA T. KIDDER, Fort Wayne
WILLIAM A. KURTZ, Tipton
DONALD R. LA FOLLETTE,
New Albany

DAVID H. LINDAUER, Princeton
H. ALLISON MILLER, Marion
VIRGIL MILLER, Akron
JAMES McEWEN, Terre Haute
KENNETH O. NEUMANN,
Lafayette

CHARLES OLCOTT, Aurora
DOUGLAS W. PRICE, Nappanee
SAMUEL RICHTER, Merrillville
JOHN P. SCHERSCHEL, Bedford
GEORGE W. SEWARD,
North Manchester

TOM SHIELDS, Richmond

E. T. STAHL, Lafayette

FRANCIS T. STOUT, Muncie

RICHARD T. STOUT, Elkhart

ROBERT W. VAN BOKKELEN,
Mooresville

PAUL C. F. VIETZKE, Valparaiso

HORACE R. WILLAN,
Martinsville

JOHN D. WILSON, Evansville

Dr. John W. Beeler, speaker of the House of Delegates, assumed the chair.

Report of Credentials Committee

Dr. Robert M. Brown, chairman of the Credentials Committee, reported 132 delegates, 13 trustees, 7 past presidents and 1 president in attendance at the first meeting. The chair announced that, inasmuch as 50 constitutes a quorum, there was a quorum present for the first session of the House of Delegates. Attendance at the final meeting was 122 delegates, 13 trustees, 9 past presidents, 1 American Medical Student Association delegate.

Dr. Lester Hoyt, Indianapolis, served as parliamentarian for the House of Delegates.

Approval of Minutes

The proceedings of the 25th annual meeting of the House of Delegates held in Indianapolis and published in the December 1974 Journal of the Indiana State Medical Association were approved upon motion duly made, seconded and carried.

Introduction of Guests

The speaker introduced Dr. Richard E. Palmer, president-elect of the AMA, who spoke to the delegates at the first meeting of the House. Also introduced were Dr. Jose L. Garcia Oller, president, American Council of Medical Staffs, who spoke briefly to the House. Other guests who were introduced were Dr. Brock E. Brush, president, Michigan State Medical Society; Dr. Maurice F. Lieber, president, Ohio State Medical Association; Dr. Jack Leckie, president, West Virginia State Medical Association, and Dr. Lee C. Hess, past president of Kentucky Medical Association. The House recognized Dr. Lowell H. Steen, trustee of the American Medical Association and Dr. Patrick J. V. Corcoran, member of the Council on Medical Education of the American Medical Association.

Dr. David Crane, chairman of the Commission on Public Information, introduced Jack Post, Philip Bryant and Tim Spencer, speakers of the Speakers Bureau.

Governor Otis R. Bowen, M.D., was introduced to the House and received a standing ovation.

Address of the President

HOUSE ACTION: Ordered filed.

Good morning, and a most hearty welcome to you, my esteemed colleagues, our friends, and our invited guests.

I pledged to you, in the brochure which was sent, I hope, to all of you, that "We have a *dynamic* convention planned for you." That is what we intend: "A dynamic convention." For I believe my term as your president should end dynamically, because this past year has been exhilarating.

Yet, my appearance here before you this morning is, for me, both a sad and an exhilarating experience. That is, I am saddened to end my year's tenure as your president, an office I admire and was proud to occupy, and therefore am saddened to leave. And my sadness is deepened because I and my co-officers and co-workers worked well together and accomplished a great deal of business, disseminated many ideas, and stimulated much action. We wanted to do much, and we did. But some work remains, work we initiated or continued, but whatever, deserves more attention.

For example, I appointed an ad hoc committee to obtain, review, and digest all the material from the Joint Committee on Accreditation of Hospitals in order to coordinate and facilitate between the hospitals and the multitude of new programs and requirements of JCAH. This committee will disseminate major issues of this material to the Indiana State Medical Association to be passed on to our hospitals' medical staffs. This vital link of communication among the JCAH, our association, and our hospitals' medical staffs is much needed. It deserves our support. I wholeheartedly recommend its further implementation and continuance.

Also, I believe in the Tel-Med facility. It is a fact that the operation is successful. But I suggest that its financial backing come from the citizenry it helps to educate and to keep healthy. It is time other sources of support came forward to continue and to expand Tel-Med. I recommend other avenues of financing be investigated in order to turn Tel-Med over to local control.

Many, if not most, of you know of my special interest in sports medicine. I have advocated not only increased cooperation between schools and medical personnel for safer sports programs, but also I have articulated the proposals for a state Sports Medicine Advisory Committee, to direct intense summer training in sports medicine for high school faculty. We need qualified sports trainers

with proper certification to educate, to prevent and to treat school-connected medical situations. We need more attention and work on this vital proposal.

Do many of you remember that in my inaugural address, one of my proposals about which I had great concern and in which I invited this association to take an interest was the development of medical education in our public schools? I am convinced that physicians *should*, even *must*, become more involved in our educational process, particularly at the high school level. We in the medical profession have the knowledge and experience our teenagers desperately want and need. They are plagued with problems of drugs, sex, venereal disease, tobacco, alcohol, and all the other painful and awkward problems of "growing up." And *how we could help!!!* And they want us to. My experience proves to me that they will listen and learn from professionals who are sincerely interested in them. Therefore, I continue to recommend the Indiana State Medical Association to request a program from the State Board of Education which would promote the personal contact of physicians with our high schools.

I remarked earlier that I was both sad and pleased on this occasion. My pleasure comes from the fact that I am now able to turn over the obligations and responsibilities of the presidency to a deserving successor, Vinny Santare. Moreover, I am pleased that during this past year I have seen and participated in some hard work that has "paid off," that has culminated in a result both tangible and desirable. I am particularly rewarded when I remember that one year ago I expressed my interest in the area of medical ethics. Well, that interest has created the formation of the Medical Ethics Committee whose reason for existence is to embody constructive criticism and personalized assistance. The committee investigates matters concerning medical ethics and professional relationships, and then advises and counsels association members in these matters.

Yes, I am pleased with the Medical Ethics Committee, as I am with another of my inaugural proposals that I offered to this association to think about and then to work on.

The second, about which I am even more excited, is the proposal of a patients' compensation board which became House Bill 1460. I decided last year that my first priority as president was to direct the association and the public's attention to the medical liability problem, really a dual problem, a two-headed monster that threatened not just the professional lives of many doctors, but the quantity and quality of health care for the people of Indiana. The two heads of the monster were the increased number and amounts of malpractice suits, and

the decreased number of doctors who were able to obtain medical liability insurance. From the formation of a committee to the formation of multiple task force groups came the plans for legislation. Well, to make the tale of a long and arduous journey short, we were rewarded with a good bill, H.B. 1460, which although it does not encompass all we want or need, and is not a panacea for all our ills, is nevertheless a strong step in the right direction. And the proof that it has achieved something significant is ample. For example, it has literally saved a great number of doctors throughout our state. I know that some older ones seriously considered retirement in the face of the two-headed monster before passage of H.B. 1460. Now, however, they have continued to practice. And a specific example is even stronger evidence: I know a young anesthesiologist whose insurance was over \$21,000 but, because our work for legislation got results, it is now \$9,000. This is still high but it is a savings of \$12,000 for this individual. To be sure, actuary studies indicate that the insurance premium spiral will not slacken for two or three years: nonetheless,, I believe our legislation will keep it within reason and ultimately decrease it.

In addition, I know our work in this legislation is worthwhile when I hear reports from doctors who, prior to H.B. 1460, had difficulty in recruiting colleagues, but *now* have numerous applications. Why? Young doctors are no longer fleeing the profession or Indiana, they are seeking us out!!! Furthermore, young doctors are recognizing this association as a leader, which I believe was not always the case before we began to work together, to lead, and to better the conditions for the practice of medicine in Indiana.

Well, ladies and gentlemen, so much for the efforts of the past year. Allow me for a moment to survey the future and to predict an area to which we may well direct our energies. On the horizon I see increased pressure for some kind of national health insurance. Although I do not stand against the idea in some respects—that is, federal assistance to private carriers for patients with catastrophic illnesses—I must certainly stand against the idea of government deciding the program and its administration. I foresee a great loss of confidentiality, a great erosion of confidence and trust so necessary to physician-patient relations, and a great loss of effort and money by government, medicine, and the public alike.

I also have another stand: I am for the concept of preventative medicine, not just lip service, but real service to the idea. That is, let us be convinced that many medical problems can be eased or even eliminated by more careful and frequent examinations and by public

education. This is what I call "Autopsies during a patient's life rather than one after his life is over." Getting doctors into the schools, educating the public, researching and advocating preventative medicine, all of these things would raise the quality as well as the quantity of human life. My last two proposals are related, by the way. If we continue to neglect preventative medicine, very likely the pressures for national health insurance will increase.

Now it is time to conclude. As I end my term as your president, I wish to salute my fellow officers, the association we serve, this dynamic convention, and our incoming officers, who I know will honor and relish the work ahead. Now I am sad, and happy, and pleased with the year, with the work, both done and undone. Our association has accomplished much for our profession in the years we have been bound together, and I would like to think this year added much work and honor to this body. Let us approach the coming year and this convention with the idea that now, this moment, we begin again.

Thank you all, very, very, much

Remarks of Speaker

Any delegate may introduce a resolution from the floor provided that where a resolution has been first submitted to the Committee on Rules and Order of Business together with a written statement setting forth the reason why said resolution was not mailed to the Executive Secretary more than 45 days prior to the meeting of the House of Delegates and also setting forth in said written statement the reason why said resolution is of such an emergency nature that it cannot wait until the next meeting of the House, and that said Committee on Rules and Order of Business has approved said resolution for submission to the House, and that each delegate shall be furnished a copy before the next meeting of the House, then this subsection of the Bylaws may be suspended with respect to said resolution upon a two-thirds vote of the House of Delegates.

Committee on Rules and Order of Business is in session in the rear of the Convention Hall.

Appointment of Reference Committees

In accordance with the Bylaws, I have appointed reference committees, and the names of the members of these committees are published in the Handbook.

These reference committees are to serve during this annual convention only.

To these reference committees will be referred all reports, resolutions and measures presented to the House of Delegates at this session, except such matters

as properly come before the Board, and the recommendations of these committees shall be submitted at the final meeting of the House of Delegates at 9 a.m., EST, Wed., Oct. 22, for acceptance in the original or modified form, or for rejection.

Each reference committee consists of at least five members; the first member named is chairman. Will committee members please stand as their names are called?

REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

C. David Ryan, Columbus (Bartholomew-Brown), *Chairman*
B. T. Maxam, Indianapolis (Marion)
Peter E. Gutierrez, Crown Point (Lake)
Lowell W. Painter, Winchester (Randolph)
Fred W. Dahling, New Haven (Allen)

REFERENCE COMMITTEE NO. 1

Peter E. Gutierrez, Crown Point (Lake), *Chairman*
Warren L. Bergwall, Muncie (Delaware-Blackford)
Hugh L. Williams, Indianapolis (Marion)
Charles O. Hamilton, South Bend (St. Joseph)
David E. Ross, Jr., Gary (Lake)

REFERENCE COMMITTEE NO. 2

C. David Ryan, Columbus (Bartholomew-Brown), *Chairman*
Kenneth J. Ahler, Rensselaer (Jasper)
Richard A. Brickley, Indianapolis (Marion)
William F. Kerrigan, Connersville (Fayette-Franklin)
Marvin E. Priddy, Fort Wayne (Allen)

REFERENCE COMMITTEE NO. 3

Lowell W. Painter, Winchester (Randolph), *Chairman*
James L. Mount, Bedford (Lawrence)
Richard L. Glendening, Logansport (Cass)
Morris E. Thomas, Indianapolis (Marion)
Robert M. Seibel, Nashville (Bartholomew-Brown)

REFERENCE COMMITTEE NO. 4

Fred W. Dahling, New Haven (Allen), *Chairman*
E. Edmund Storey, Indianapolis (Marion)
Charles D. Egnatz, Schererville (Lake)
Betty J. Dukes, Dugger (Sullivan)
Thomas M. Harmon, Evansville (Vanderburgh)

REFERENCE COMMITTEE NO. 5

B. T. Maxam, Indianapolis (Marion), *Chairman*
Charles W. McClary, Bloomington (Owen-Monroe)
E. Henry Lamkin, Jr., Indianapolis (Marion)
Frank B. Adney, Jr., Richmond (Wayne Union)
James A. Marvel, Evansville (Vanderburgh)

CREDENTIALS COMMITTEE

Robert M. Brown, Marion (Grant), *Chairman*
Lee F. Dupler, Frankfort (Clinton)
Max N. Hoffman, Covington (Fountain-Warren)
Walfred A. Nelson, Gary (Lake)

TELLERS

James R. Daggy, Richmond (Wayne-Union)
Grayson B. Davis, Lafayette (Tippecanoe)
Michael O. Mellinger, LaGrange (LaGrange)
L. Ray Stewart, Evansville (Vanderburgh)

AMA Delegates and Alternate Delegates

The following were elected to a two year term as delegate and alternate delegate to the American Medical Association, their terms to expire Dec. 31, 1977:

Delegate, Patrick J. V. Corcoran, Evansville; alternate, Thomas C. Tyrrell, Hammond; delegate, Peter R. Petrich, Attica; alternate, Marvin E. Priddy, Fort Wayne.

Selection of City for 1980 Meeting

It was moved, seconded and carried to hold the 1980 meeting in Indianapolis. Dates to be set by the Board of Trustees.

Election of Officers

OFFICERS: Dr. Vincent J. Santare of Munster assumed the office of president and Dr. John W. Beeler of Indianapolis was elected president-elect.

Dr. Arvine G. Popplewell, Indianapolis, was elected treasurer.

Dr. Joseph F. Ferrara, Franklin, was elected assistant treasurer.

Dr. Eli Goodman of Charlestown was elected chairman of the Board of Trustees. Dr. Joe Dukes of Dugger was elected chairman of the Executive Committee and Dr. Richard G. Ingram of Montpelier was elected a member of the Executive Committee.

Dr. William R. Cast of Fort Wayne was elected speaker of the House of Delegates and Dr. Lloyd L. Hill of Peru was elected vice-speaker of the House of Delegates.

Election of Trustees

Dr. John G. Pantzer of Indianapolis was elected Trustee of the Seventh District and Dr. Jack M. Walker was elected Trustee of the Eighth District. Three trustees reelected in 1975 were: Dr. Paul W. Holtzman, Bloomington, Sec-

ond District; Dr. Cleon M. Schauwecker, Greencastle, Fifth District, and Dr. James A. Harshman, Kokomo, Eleventh District.

Dr. Paul F. Muller, Indianapolis, was elected in 1975 alternate trustee for the Seventh District. Two alternate trustees reelected in 1975 were: Dr. Glen Ward Lee, Richmond, Sixth District, and Dr. Leonard W. Neal, Munster, Tenth District.

Address of President-Elect Vincent J. Santare, M.D.

HOUSE ACTION: Ordered filed.

Many people have asked what my intention is for the direction of the ISMA in the coming year. I do not feel that ISMA can afford the luxury of permitting its President to begin new programs of his own selection when we are so vitally embroiled in our present struggle. With this in mind, I am asking this House of Delegates to establish definite policies to which I can direct my efforts. Such policies, should be positively directed to the improvement of patient care, which includes action to prevent or deter legislation or governmental intrusion that could possibly result in poorer care or the squandering of resources and finances. In order to cooperate with such direction, I strongly urge the ISMA to give the diligence and perseverance that was demonstrated in our recent efforts to sponsor malpractice legislation.

With some excellent legal assistance, the ISMA formulated the prototype malpractice bill. It then united across the entire state to encourage the Indiana Legislature to pass this bill. In our strategy, we enlisted all the medical professionals and institutions in order to increase our effectiveness. We raised our dues to obtain a "war chest," which was augmented by contributions from a foundation established by some of our associates. Doctors testified at public hearings of the legislature and their strong motivation, intimate knowledge and personal conviction were powerful arguments.

An example was the dean of the Indiana University School of Medicine testifying that his malpractice policy might not be renewed. This made it evident that the basic problem was not medical malpractice, a culpable fault, but was medical maloccurrence, which could be a natural, undesirable consequence of any illness.

Cardiologists testified that, in answering a code blue for another doctor's patient, they could be innocently involved in malpractice litigation. This demonstrated the dilemma of a doctor responding in the best traditions of his profession and, in the same act, involving himself in complexities which resulted in embarrassment or on some occasions loss

of time or money, and occasionally to difficulty in obtaining renewal of his medical liability insurance.

Our most effective allies were the people who were educated by leaflets in the doctors' offices, by radio and television talks, and by direct contact with physicians. They were made to understand that the malpractice crisis resulted in increased medical costs and in defensive medicine which was not a better quality but certainly a more expensive therapy. They were won to our side by a direct appeal to their logic and sense of justice and not by threats of withholding medical care. This is the key to success in enlisting the public in our cause.

Last year the House of Delegates voted a \$10 dues increase to fund our expenses in developing malpractice legislation. This appropriation was well short of the mark and, without the financial help of the Federation of Medical Specialties, our campaign could have foundered. I am suggesting that this House of Delegates consider adequate support for the remaining work to be done. I encourage a dues increase to fund our continuing struggle. I request our members to persevere in their dedication and efforts which will be necessary in the next year.

The specter of national health insurance is still appearing in the Congress. That such a bill has not been passed is not due to any particular efforts on our part, but because of the condition of our strained inflated economy. Some of our political theorists or, more appropriately termed, opportunists are attempting to show that national health insurance is a panacea. They promise equality of medical care without considering cost of medical care. This thinking promises physical Utopia, but portends economic famine. HEW cannot live up to the promises that Medicare offered to our senior citizens. This inability is disguised by publishing regulations which would decrease reimbursement for medical care. Our role is not only to challenge such unfair regulations but to inform the public of the truth.

Finally, we come to government intervention, such as PSRO in 92-603, HSA in 93-641 and the Health Manpower Bill, which is still in committee. The Legislator's argument is that if the government pays the bills for Medicare and Medicaid, it has the right to police the quality of care. No one can argue against the right of a consumer to seek quality for value received. On the other hand, it is unjust to dictate a single means of obtaining quality medical care. Medicine has taken up the gauntlet of judicial challenge to replace legislative persuasion in the arena of governmental intrusion.

A recent success is the injunction obtained by the AMA against the U.R. regulation. Although such action is ex-

tremely effective, let us remember that there are other methods of meeting these challenges and let us not hinder our maneuverability in defending against improper government intrusion into medicine.

Let me conclude by saying we have begun a successful course of action; the game is not over. Let us continue with the same enthusiasm and results.

**Report of Mrs. Edsel S. Reed,
President of the Woman's
Auxiliary to the Indiana State
Medical Association**

HOUSE ACTION: Ordered filed.

Dr. Wilhelmus, Dr. Santare, Trustees, Members and Guests of the Indiana State Medical Association.

First, I must say that we are proud to be an auxiliary to such a distinguished group. We appreciate the guidance and assistance of your president, Dr. Gilbert Wilhelmus; our advisors, Dr. William Sholty and Dr. Beach Gattman; the ISMA staff and Mr. Waggener. Our special thanks to each of them.

It is also our pleasure to have Indiana's First Lady, Mrs. Otis Bowen, Beth, immediate past president of the auxiliary, as our advisor. We are most grateful for her leadership this past year. She presented the auxiliary report, with special emphasis on legislation to the AMA Auxiliary in June.

Again this year we are cooperating in Immunization Action Month. It is my privilege to present a Proclamation from the Governor to this House of Delegates proclaiming October as Immunization Action Month in Indiana. He urges our citizens to join this observance both by insuring that their own children are fully immunized and by encouraging the efforts of physicians and public health officials to protect the health of the community as a whole through immunization.

Dr. Wilhelmus: It is with great pleasure that I present to you this Proclamation signed by Otis R. Bowen, M.D., Governor of Indiana.

**STATE OF INDIANA
EXECUTIVE DEPARTMENT
INDIANAPOLIS**

PROCLAMATION

Executive Order

**TO ALL TO WHOM THESE PRESENTS MAY
COME, GREETING:**

WHEREAS, the good health of the citizens of Indiana is essential for the social and economic wellbeing of the State, and

WHEREAS, many diseases are now

completely preventable by the administration of safe vaccines, and

WHEREAS, the early and complete immunization of children protects both the children themselves and the community as a whole from the threat of disease, and

WHEREAS, children's immunity levels in the United States and in Indiana are still low enough to permit the spread of disease, and

WHEREAS, the Indiana State Board of Health is participating in the national observance of Immunization Action Month sponsored by over twenty organizations concerned with health care;

NOW, THEREFORE, I, Otis R. Bowen, Governor of the State of Indiana, do hereby proclaim the month of October, 1975, as

IMMUNIZATION ACTION MONTH in Indiana, and urge our citizens to join this observance both by insuring that their own children are fully immunized and by encouraging the efforts of physicians and public health officials to protect the health of the community as a whole through immunization.

SEAL

**IN TESTIMONY WHERE-
OF**, I have hereunto set my hand and caused to be affixed, the great seal of the State of Indiana, at the Capitol, in the city of Indianapolis, this 4th day of August, 1975.

**Otis R. Bowen, M.D.
Governor of Indiana**

For the sake of brevity, I would like to focus attention to the Resolution your Board of Trustees will submit to you on behalf of the Auxiliary. It includes many and varied projects that have been utilized by the Auxiliary to assist the Indiana State Medical Association in its programs for medicine, medical education and public health. Thanks to your continued support, Indiana again received a State Merit award for its \$50,037 contribution to AMA-ERF. The auxiliary has promoted and assisted with programs for all ages, beginning with prenatal clinics, well-baby clinics, immunization action month, day care centers, and selected child abuse and neglect (SCAN) for children, to youth organizations, camp for teenagers, to planned parenthood, blood pressure clinics, blood bank and telephone hot line for adults, to nursing home visitation and Meals on Wheels for the elderly.

This current year the auxiliary assisted the ISMA in a most important endeavor—legislation. We promoted and participated in many legislatively oriented

activities—such as writing letters, telephone committees, bus trips, coffees for legislators and people of the community, in addition to our annual Legislative Day which has been most successful in establishing rapport with our legislators. We feel that these and other activities of the auxiliary are beneficial to all members of the Indiana State Medical Association.

We continue to emphasize membership. We have voting delegates from our members-at-large. There are resource persons in some unorganized counties. If your wife is not an auxilian, please encourage her to join us. As the national slogan so aptly states:

JOIN US—WE CAN DO MORE TOGETHER.

It has been our pleasure to work with Dr. Gilbert Wilhelmus, your president, and we look forward to the leadership of Dr. Vincent Santare, your president-elect.

Report of Walter R. Hunter President, Indiana Chapter of the American Medical Student Association

HOUSE ACTION: Ordered filed.

The Indiana University Chapter of the American Medical Student Association (AMSA), formerly the Student American Medical Association (SAMA), had a busy and profitable year. The officers for the 1975-1976 academic year were elected in the spring of 1975, the new officers being: Miss Dorothy Cummings, president; Mr. Walter R. Hunter, vice-president; Miss Carol R. Giltz, secretary; and Mr. Eugene Griner, treasurer.

The first project was the National Convention of AMSA held in Chicago during March 6-10, 1975. Three delegates and four alternates from I.U. attended—three officers from the 1974-1975 year and the aforementioned officers. The ISMA paid the expenses for one delegate with the funds coming from pharmaceutical companies, the school, and other sources to defray expenses of the other Hoosier delegates. Indiana's delegation was the largest in attendance. Reference committees dealt with many current issues: PSROs, National Health Insurance, alternative plans to mandatory service in the National Health Service Corps, etc. The convention was worthwhile and informative and gave us a better perspective on the issues facing today's medical professionals.

At the beginning of summer we received a letter from the National Headquarters of AMSA concerning the Health Manpower Act of 1975 (H.R. 5546), introduced by Rep. Paul Rogers, D-Florida. This act, if law, would require repayment of capitation funds by medical

schools unless certain programs were initiated at the schools. The officers at I.U. made copies of that letter, which contained the specifics of the proposed bill, and mailed these to all students of the I.U. School of Medicine, urging them to write their congressmen to oppose this bill.

The Medical Education Community Orientation (MECO) Program sponsored by AMSA placed 44 sophomore students in 28 locations throughout the state during the summer months. These students worked in hospitals, rotating through various departments, gaining valuable clinical experience to supplement their pre-clinical education. This program is now being planned for the summer of 1976 for the students presently in their first year of basic science.

At the beginning of the present school term AMSA and the sophomore class co-sponsored a picnic for the freshman and sophomore classes. This was to acquaint the members of each class since the size and scheduling of classes at the medical school is less than ideal for the two classes to become acquainted.

The officers have completed a listing of the Senior Electives available at I.U. School of Medicine, at the request of the National Headquarters of AMSA. This list, along with others like it from other medical schools, is now available upon request to any medical student in the United States who might wish to enroll in an elective at another medical school.

The I.U. School of Medicine Student Directory is currently at the printing press and should be ready for distribution in December. A listing in the directory is voluntary on the part of the students but the response was greater this year than last and this is apparently a service greatly appreciated by the student body. The directory, published by AMSA, includes the names, addresses and telephone numbers of medical students in Indianapolis and on regional campuses.

The AMSA Video Journal is still being sent monthly from the National Headquarters. This consists of short video-taped cassettes on special topics of medicine which are available to any student for viewing in the video carrels of the media center in the Medical Science Building.

Through AMSA, students this year can receive a BankameriCard from the Indiana National Bank of Indianapolis. Also available this year through our organization is a discount price on the CIBA Frank Netter Anatomical Illustrations and Text.

Of current interest to medical students is a series of six noon seminars, sponsored by AMSA, to be presented by Indianapolis attorney Eugene Burris. Mr. Burris will speak in October, November, January, February, March, and April on

the topics of: (1) Estate Planning; (2) Tools of Estate Planning; (3) Aspects of Medical Malpractice; (4) Tax Advantages; (5) Professional Incorporation; and (6) Purposes of Life Insurance, respectively. We have had help with this project from Mr. Charles Stevens, insurance representative of the Minnesota Mutual Insurance Company. Mr. Stevens also has worked with medical students to explain the benefits of the AMSA life insurance policy.

For several months one of the officers of AMSA has been permitted to attend the Board of Directors meetings of the Marion County Medical Society. These meetings have been very informative and beneficial to our understanding of the policies and programs of the organization of medicine at the county, state, and national levels.

The AMSA Chapter of the Indiana University School of Medicine is grateful to the Indiana State Medical Association for its support of our programs and for allowing a student delegate to attend the annual convention of ISMA. Through your efforts at the state and national levels and ours at the medical school and with communication lines open between our organizations, I hope that we can continue to support, encourage and benefit medicine in Indiana to the ultimate benefit of our patients.

Report of Joe M. Black, Chairman of Blue Shield Board of Directors

HOUSE ACTION: Ordered filed.

There has been a great deal of concern and frustrations by Indiana physicians relating to the government regulations under Medicare (Title XVIII) and Medicaid (Title XIX). Occasionally, some of the hostility regarding these regulations is vented toward the Medicare carrier (Blue Shield of Indiana) and there is often a feeling among Indiana physicians that Blue Shield is nothing more than an arm of the federal government. The facts are that we at Blue Shield are also many times frustrated. Frustrated by the fact that doctors on the Blue Shield Board, both locally and nationally, spend a great deal of time and energy in protesting unfair federal regulations, in testifying before congressional committees, and, in general, attempting to represent the best interest of their fellow physicians and their patients with very little awareness from our own colleagues. Let me give you some examples of what we have done recently.

A copy of the Federal Register dated April 14, 1975, was received and reviewed by Blue Shield in early May and immediately referred to the Professional Relations Committee. The committee instructed Blue Shield staff to

write a letter of protest to the commissioner of Social Security outlining some initial concerns and requesting an extension of the 30-day comment period so that the impact of the regulation could be studied in further detail. A similar protest, was also made by the American Medical Association. In early July, we received a response to our protest from Mr. Tom Tierney, director of the Bureau of Health Insurance, which said, in part, that since the effective date of the revision (July 1, 1975) had already passed, "an extension of the comment period . . . could serve no useful purpose." At the July Blue Shield Board meeting, the exchange of correspondence was reviewed and the Board instructed me to draft a letter protesting the lack of consideration on the part of Social Security Administration to extend the 30-day comment period and also pointing out our concerns with the reimbursement formula.

On a national level, the National Association of Blue Shield Plans also submitted testimony before the subcommittee of the Ways and Means Committee on the same subject.

As a result of the protest filed from Indiana Blue Shield, other Blue Shield Plans, and the National Association of Blue Shield Plans, we understand that the commissioner of Social Security Administration, Mr. James Cardwell, has written a letter to Congressman Paul Rogers asking that the Ways and Means Committee consider a technical amendment to 92-603 (the source of the above regulation) that would restrict any roll-back in fees from the previous year. A sampling of our own profile information would indicate that approximately 22% of the fees calculated using the new economic index formula are now resulting in roll-backs from the amount paid in the previous year. (51% have been increased and 27% show no change). Just last week the subcommittee on Health of the Ways and Means Committee passed the proposed technical amendment and there is a possibility that it will now be reported out favorably by the Ways and Means Committee this week for a vote by the entire house.

I hope this will serve as an example to show you how your Blue Shield Plan is taking concrete action in attempting to protest the action of a federal regulation that is neither beneficial to physicians or the public in general. I have samples of testimony given on other subjects. Somehow, we (Blue Shield) have failed to communicate to the medical community that we are not an extension of government bureaucracy.

Reports of Officers

Executive Secretary

HOUSE ACTION: Referred to Board of Trustees for implementation and action on Resolutions No. 74-11 and No. 74-16.

In accordance with the directive of the House of Delegates and the Constitution and Bylaws, your secretary lists herewith the disposition of actions taken by the 1974 Meetings of the House of Delegates, Indiana State Medical Association.

Actions of the 1974 House of Delegates and Disposition:

RESOLUTION 74-1

Resolved, that the Indiana State Medical Association again prepare and seek to have introduced into the General Assembly a bill defining the term "physician" as applying only to persons holding the academic degree of Doctor of Medicine, or Doctor of Osteopathy.

ACTION:

Legislation to define the word "physician" was included in the Medical Practice Act, Chapter I—Definitions and Exclusions, Item (g) which reads "physician" means any person who holds the degree of doctor of medicine or doctor of osteopathy or its equivalent and who holds a valid unlimited license to practice medicine or osteopathic medicine in the state of Indiana . . .

RESOLUTION 74-6

This resolution was substituted in lieu of Resolutions 74-7, 74-8, 74-9, 74-14, and 74-22, as amended, and referred to the President of the Indiana State Medical Association. The resolution had to do with parliamentary maneuvering by the AMA leadership to prevent a floor debate of a PSRO recommendation. It was resolved that a letter express disapproval of the lack of free debate on the floor of the House of Delegates of the AMA be written by the President of the ISMA.

ACTION:

This was accomplished.

RESOLUTION 74-11

Resolved, that ISMA schedule its annual meeting so that the scientific sessions not conflict with business meetings and also resolved that negotiations be initiated with the Indiana Academy of Family Physicians, the various other state specialty societies and the Indiana University School of Medicine to develop a coordinated scientific and educational

annual program of meetings during one period of time . . .

ACTION:

There was no action taken on these matters.

RESOLUTION 74-12

This resolution dealt with the creation of a section on clinical pharmacology and therapeutics. The House did not adopt the creation of this section until such an organizational program could be presented to the 1975 House of Delegates:

ACTION:

No program received as of August 1, 1975.

RESOLUTION 74-16

Dealt with proposals for national licensure and periodic relicensure of physicians as now being advanced in the Congress and asked that the ISMA communicate concerns embodied in the resolution to all candidates for the State General Assembly and national Congress and regularly remind these legislators of such concerns and that the ISMA delegation to the American Medical Association sponsor appropriate measures to see that the matter of evaluation of competency be implemented.

ACTION:

Matter brought to the attention of the Board at the June 8 meeting by the chairman, and no action was taken.

RESOLUTION 74-17

Resolved that Indiana State Medical Association affirm the professional correctness of interest charges imposed on overdue medical bills and instruct the delegates to the AMA to express this sentiment to the national organization.

ACTION:

Such a Resolution labeled C 74-5 was introduced before the AMA. The Reference Committee recommended that the resolution not be adopted and recommended adoption of the Judicial Council Report D in lieu thereof. The House adopted the following: "It is not in the best interest of the public or the profession to charge interest on an unpaid bill . . ." It is not improper, however, for a physician to add a service charge, equal to the actual administrative cost of rebilling, on accounts not paid within a reasonable time. Patients must be notified in advance of the existence of this practice.

RESOLUTION 74-20

This resolution referred to the Board of Trustees pertained to safeguards on data handling, pointing out that access to stored patient data be absolutely determined by physicians accountable to the Indiana State Medical Association.

ACTION:

In conjunction with the development of I-MEDIC, it was brought to the attention of the Board the intent of 74-20 and it was further pointed out that I-MEDIC is in the spirit of compliance with 74-20. The Board is currently proceeding with the development of I-MEDIC.

RESOLUTION 74-25

Pertains to medical liability insurance, its unavailability, and instructions to the Board of Trustees to work with the presidentially appointed ad hoc committee to gather information with recommendations within thirty days to be acted upon definitely at a special open meeting of the Board within sixty days.

ACTION:

The president and the Board carried out this responsibility.

RESOLUTION 74-27

Revision of Blue Cross-Blue Shield regions. This resolution was referred to the committee on insurance. It stated that the system of multiple areas with varying fees for similar services be abolished and that benefits become uniform and a single schedule of payments applied to the entire state.

ACTION:

There was no action taken by the Commission on Medical Economics and Insurance. The Board, however, at its Jan. 18, 1975, meeting passed a motion requesting Blue Shield to review the matter of dividing the state into separate economic areas for fee payment.

EXPANSION OF EXISTING HEADQUARTERS BUILDING

The House adopted the portion of this report providing space for storage and non-ISMA operation in the Association rental properties. The report spoke of moving the CHAMPUS Department and Tel-Med out of the existing building into one of the rental properties.

ACTION:

This has not been accomplished. The Executive Committee has, however, worked through the year on rezoning and preparation of one of the residences for the move.

FUTURE PLANNING COMMITTEE

The House adopted the Future Planning Committee report with that portion concerning optional one-day meeting referred to the Board of Trustees and that portion on restructuring of committees and commissions referred to the Commission on Constitution and Bylaws, to be voted on by the 1975 House of Delegates.

ACTION:

Restructuring of commissions and committees was considered by the Commission on Constitution and Bylaws. An attorney was authorized by the commis-

sion to prepare a report with appropriate wording to make these changes.

STUDENT LOAN COMMITTEE

The report was referred to the Board of Trustees with the following options to be considered: (1) Restructure of the committee, (2) transfer the loan money to the AMA-ERF, and (3) discontinue the fund and/or billing for this loan committee.

ACTION:

A tentative agreement has been arrived at which would bring the ISMA student loan fund to almost parallel requirements with that of the AMA-ERF. (See Student Loan Committee Annual Report.)

COMMISSION ON CONSTITUTION AND BYLAWS

The House referred to the Commission on Constitution and Bylaws a suggestion to incorporate the following sentence under Chapter VI—Duties of Officers: "The duties of the Speaker will be patterned after those performed by the Speaker of the AMA House of Delegates."

ACTION:

The commission discussed duties of the Speaker of the House of Delegates. It was the opinion of the commission that the operation of the House of Delegates should be strictly left to the Speaker of the House. This recommendation is to be made in the commission's report to the House of Delegates.

COMMISSION ON LEGISLATION

The House adopted the commission's report and referred the portion concerning the Medical Practice Act to the Commission on Medical Education and Licensure for final perusal and to the Commission on Legislation for implementation.

ACTION:

This was accomplished and the State Legislature passed the new Medical Practice Act.

COMMISSION ON PUBLIC INFORMATION

The House recommended that Tel-Med be continued until funds run out or outside funding is found.

ACTION:

Tel-Med, since the action of the House, has received additional grants from RMP and from Blue Shield. The Board of Trustees is currently seeking additional sources.

COMMISSION ON VOLUNTARY HEALTH AGENCIES

The House stated that further consideration be given to establish a mechanism whereby local agencies may be approved by county societies and thereby

receive approval of the Indiana State Medical Association.

ACTION:

There was no action taken on this matter during 1974-75, but in previous action of the commission, it was expressed that ISMA could not survey and approve all of the local units of the statewide voluntary health agencies. In the past the commission has encouraged local societies to establish criteria for local voluntary health agency units.

The following highlights some of the many activities of the ISMA Headquarters Staff which are carried out on an ongoing basis year after year.

PATIENT'S COMPENSATION ACT

The one subject which is predominant is the passage of H.B. 1460, the Patient's Compensation Act.

Along with the strategic planning by the president, the committees and the Board of Trustees was the supportive action of the ISMA staff working diligently side by side with the leadership of the Association to accomplish a goal which was achieved in spite of countless hurdles and potential pitfalls.

During the course of activity in passing the bill, hundreds of calls were received from all over the country—from medical society officers, staff personnel, and interested individuals—asking for the latest information, copies of the law, facts on promotion in the public press, approach to legislators, lobbying activity, financing, and overall strategy.

This Act has been heralded throughout the nation as a monumental achievement and an important landmark in the field of legislation.

CME ACCREDITATION PROGRAM

The accreditation of continuing medical education activities by hospitals, county medical societies, specialty groups, and allied health organizations, continues to grow in volume as more of these groups have become aware of the value of such accreditation to the individual member of the Association.

The ISMA was a leader in the country in receiving approval from the AMA in evaluating these programs. Behind the scenes of such activity are the endless volume of correspondence, the planning for site team visits, meetings of committees, and other details carried out by your staff.

PRECEPTORSHIP PROGRAM

An important continuing program is the preceptor screening function of the ISMA headquarters working in conjunction with the Preceptor Committee and the Indiana University Department of Family Practice. This program provides for senior medical students to spend time at the elbow of a practicing physician in learning the applied skills of

medical care. It is a highly successful endeavor and is sought by the medical student in his quest to understand more about his chosen profession.

THE ANNUAL RETREAT

The Annual Retreat, conducted by the ISMA in cooperation with the faculty at Indiana University School of Medicine and students from all of the classes (freshman through senior), is also a successful, continuing program. This past year the sixth Retreat was held at the Brown County Inn. Approximately 80 participate each year in a two-day "rap session" which because of its casual informality results in a closer working relationship between the practicing physicians of Indiana, the faculty, and the student group.

SPEAKERS' BUREAU

The Speakers' Bureau of the ISMA will have completed one year of activity and is being utilized extensively. Many requests for speakers to appear before such organizations as Rotary, Kiwanis, Optimist groups, etc. are channeled through the ISMA headquarters to the coordinators of the program, the Hopkins Syndicate, Inc. in Mollott, Indiana. The speakers' subjects include: "The Future of Freedom," "Crisis, Crisis, Crisis," "America As I See It," "Freedom of Choice," "Beware of the Trojan Horse," "America's Still the Promised Land," "Let's Fulfill America's Dream," and "Beware of Big Brother."

AWARDS

This year also marked the greatest number of applications from Indiana's press, radio and television stations in competition for the three awards given each year by the Association for outstanding reporting and writing on medical subjects. Initiated in 1963, the awards program has grown in stature with the communications media and has attracted in growing numbers the attention of fine reporters and writers. Application forms for all the media and for county medical societies are sent continuously at the first of the year and upon receipt are reviewed by the Commission on Public Information, who make the selections.

Also widely sought is the Physician Community Service Award, which is given to one member a year for his voluntary contribution of time and effort to community projects not necessarily related to the medical profession and its activities.

EMERGENCY MEDICAL SERVICE

Since the organization of the Governor's Commission on Emergency Medical Service, the ISMA Commission on EMS has established a close working relationship with the executive director of the Governor's Commission, Mr. Philip Martin, and the chairman of the Governor's

Commission, Dr. James Dillon. All members of the ISMA commission are kept informed by Mr. Martin on the Governor's Commission activities, currently concentrating its efforts on training ambulance technicians and on setting up a good system of communications throughout the state. The Headquarters has worked closely with Mr. Martin's staff in the provision of booklets, leaflets, and policy statements on EMS from the ISMA, the AMA, the federal government and other bodies currently concerned with emergency medical service.

INFORMATION REQUESTS

Your Headquarters is constantly called upon for information and assistance—the range of which is wide and varied. This might include putting a television news reporter in touch with an appropriate spokesman on a given subject to providing a student with the history and background of medical opposition to socialized medicine, or providing information of policy on acupuncture, abortion, Medicaid, Medicare, venereal disease, or utilization review.

TEL-MED

Tel-Med is headquartered and staffed in the offices of ISMA and is open for calls six days a week. The program attracts callers from throughout the state and the library continues to grow with the addition of new tapes on an ever-increasing variety of medical subjects. From March, 1973, through June, 1975, Tel-Med has received 313,823 calls. The overall average number of calls per day computed in June was 193 for Marion County local calls and 311 for the statewide WATS.

CHAMPUS

Your Association continues to administer the CHAMPUS program and has since its inception in 1957.

The administration of the Indiana program continues to receive the plaudits of the Federal Government. Of all the fiscal administrators, the Indiana administrative cost is the lowest in the nation. The Indiana cost for processing a claim is \$2.88 per claim. The highest cost in the nation is \$14.14, and the national average is \$6.47 per claim. For the period April 1, 1974, through March 31, 1975, we have paid a total of 24,625 claims to physicians who have received \$2,067,823.

The fear that we had a year ago that they were going to revise the CHAMPUS program into a program similar to Medicare has been postponed, according to federal sources. With the flow of claims increasing, it now requires a full time staff of six persons. The CHAMPUS department will be moved, and may have been moved by the time you receive this report to 3942 North Pennsylvania Street.

COMMUNITY/PHYSICIAN PLACEMENT

The Association's membership department continues to act as a clearing house for physicians and communities needing contacts for mutual consideration of placement in both rural and urban areas.

MEMBERSHIP DEPARTMENT

The membership department of the Association entered into the computer age during this year by converting its membership files into the American Medical Computer Assistance Program (AM-CAP). Through this system the ISMA now has available to the membership department a record entitled "Physician Profile Record Card."

The ISMA file under the new combined computer system now contains records on 5,050 Indiana physicians with approximately 300 non-members included in this number.

Under the system, the files on Indiana physicians are updated daily with such information as address changes, transfers of membership and dates and status of deceased members.

Dues bills to members are also handled through the AM-CAP program. The system also provides fast service on mailing labels for the Association in instances of promoting the ISMA convention, mailing the Newsflashes, and for mailings to specific district medical societies.

The system has great potential in the future for maintaining continuing medical education records of ISMA members, convention attendance information and other data.

COMMISSIONS AND COMMITTEES

Commissions and committees of the Association probably occupy the major part of the staff and Headquarters operation.

This involves arranging for meetings, sending out notices, keeping accurate records of attendance and terms for members on each commission, writing and circulating minutes, and doing the follow-up work as directed by the commissions. The staff also maintains files on commission activities, refers to appropriate commissions the information which is channeled into the headquarters from hundreds of sources involved in some field of health.

LIAISON WITH THE WOMAN'S AUXILIARY

The Auxiliary meets routinely in the Headquarters office throughout the year. The staff also assists the Auxiliary by providing them with legislative information, membership information, circulating leaflets and booklets, assisting them with requests for information and with the promotion of their meetings. The Auxiliary utilizes the mechanical equipment in the office as well as the WATS line of

the Association to maintain rapid communication with their county auxiliaries when needed.

LIAISON WITH ALLIED HEALTH GROUPS

Utilizing the Headquarters for meetings during the past year, with all of these activities supported in part through Headquarters staff participation, were the Board and Executive Committee of Regional Medical Programs, the Research Projects Allocation Committee of the Indiana Division of the American Heart Association, as well as various specialty societies and allied health groups.

The Association comes very close to operating on a continuous seven-day schedule with the operation of Tel-Med on Saturdays, meetings of the commissions on Sundays, and at least two or three meetings of subcommittees and other groups during the week.

CONVENTION PLANNING

Working in close conjunction with the Commission on Convention Arrangements, the planning of the convention constitutes involvement of the Headquarters staff in scheduling meetings, arranging for speakers' arrivals, departures, and hotel accommodations, providing speakers with needed audio-visual equipment, arranging for lunches and dinners, planning registration procedures, typing reference committee reports, promoting the meeting, duplicating the paperwork for the business session of the convention, handling individual housing, arranging press conferences, handling individual requests of newsmen for information, working with exhibitors, and generally seeing that the convention functions smoothly and efficiently.

FIELD SERVICE

The field staff of the Association continued to call on individual members of the Association and county society officers, and concentrated on contacting new members of the Association with information on the services of ISMA. They attended county society meetings throughout the year, assisting the membership in a variety of ways and also assisted in the planning of the annual meetings of the district medical societies.

During the sessions of the Indiana legislature, both field men served as the eyes and ears of the Association in observing the activities of the Senate and House of Representatives and reported these observations to the executive secretary and to the Commission on Legislation. Throughout the year they maintained close personal contact with Indiana legislators at their homes and businesses.

As part of their legislative operation they accompanied the Executive Committee on its annual journey to Wash-

ington, D.C., to meet with the Indiana congressmen and senators.

The field staff also assists the Headquarters staff from time to time on specific projects.

INTERNATIONAL TRAVEL COORDINATION

The ISMA Headquarters staff serves as coordinator for international trips sponsored by two travel agencies, INTRAV and MARITZ. The staff coordinates the mailings announcing the trips to the membership, receives the reservations and deposits from those planning to attend, and answers numerous questions concerning details of each trip.

These trips have been highly successful. In 1975, 140 Indiana physicians and their wives traveled to Rabat, Casablanca, Marrakech, Tangier, Nairobi, Mount Kilimanjaro, Belgium, Germany, France, Switzerland, and a four-day cruise on the Rhine River.

September 1, another group of 70 members and wives will tour the Balkans, including Bucharest, Istanbul, and Dubrovnik with an optional one-day trip to Kiev, Russia.

SECRETARIAL SERVICE

The headquarters office also transcribes hundreds of pages of minutes for county medical societies throughout the year; and following the direction of the county society secretary, distributes these reports to the appropriate members. These minutes, as well as countless letters and memoranda, are received on the WATS line and placed on tape by the physician-members.

The staff also serves as secretarial force for the officers and Board of the Association in their need for continuing communication with the membership and with other medical organizations, both statewide and national in scope.

Although this can only reflect a partial list of the Headquarters and field staff functions, this report will serve to illustrate the dedication of the staff in any and many endeavors, working to carry out the business of ISMA through the direction of the commissions and committees, the Board of Trustees and the Executive Committee.

As one looks back over the past years, every physician in the state of Indiana has a right to be proud of the activities of this Association. It is impossible to convey to individual members the daily activities of your headquarters and the officers in handling the many problems that confront the organization. The past year has been a fruitful one in attempting to resolve the serious problem of professional liability. It will, no doubt, be at least three years before we know whether we have resolved it. Undoubtedly, there will be efforts made to change the law during the coming years, but I am sure the Association and its commit-

tees and officers will do everything in their power to completely resolve the issue to the satisfaction of all.

The coming months and the coming years are going to present many serious challenges to this organization and its members. We have seen in the early 1950s and in 1975 a show of strength by the profession when it gets behind a common cause and "puts its shoulder to the wheel." We have proven that we are effective when we work together. The coming months and years are going to require this type of cooperation and effort if medicine is to achieve its goals. We are going to see more and more attempted federal intervention into the health care field. It is something that all must be alert to, or else we will forfeit all basic tenets upon which the medical profession is founded.

In keeping up with the trends of the future, if we are to provide the services which are due the members, and if we are to develop strong, effective programs—if this is the desire of the membership, then some thought must be given to additional funding and adequate staff to handle these various responsibilities.

The Indiana State Medical Association has a bright future ahead, and I would hope that the Future Planning Committee and the officers of the Association give serious thought to the future of the Association.

I cannot help but comment that the officers and trustees of this Association have been and are dedicated, willing men who have given their all to advance the Association to its present place, nor can I omit an expression of thanks to the loyal staff which serves you in the headquarters office. Many of them have gone beyond the call of duty in order to accomplish those things which have been accomplished.

JAMES A. WAGGENER
Executive Secretary

Treasurer

HOUSE ACTION: Referred to the Board of Trustees with the recommendation that net excess funds of the Speaker's Bureau be returned to the General Fund, and that the Speaker's Bureau be fiscally responsible to the Executive Committee through the Commission on Public Information.

In previous years we have published an abbreviated report in the September issue and carried the complete audit in the January issue of *The Journal*. The reason for this was that the audit is not made until after the close of our fiscal year (Sept. 30) and is never available in time to submit to the House of Delegates.

As was done last year, I am presenting an unaudited report of the financial condition as of June 30, 1975, and the

**INDIANA STATE
MEDICAL ASSOCIATION**

**Statement of
Financial Condition**

figures from the Sept. 30, 1974 audit, for comparison. I hope in this way it will give our members a more current review of the financial condition of the State Association.

HUGH K. THATCHER, JR., M.D.
Treasurer

Chairman of the Board

HOUSE ACTION: Ordered filed.

The Board of Trustees held an organizational meeting following the annual convention on Oct. 8, 1974, at approximately 4:30 p.m.

At this meeting new additions to the Board of Trustees were welcomed, as follows: Dr. Alvin J. Haley, Fort Wayne, elected trustee of the 12th District to fill the unexpired term of John S. Farquhar, Jr., who resigned. Dr. Martin J. O'Neill, Valparaiso, was welcomed as the new trustee for the 10th District, elected in 1974. The four trustees who were reelected and welcomed back were: Dr. Bernard B. Rosenblatt, Evansville, 1st District; Dr. Howard C. Jackson, Madison, 4th District; Dr. John O. Butler, Indianapolis, 7th District; Dr. G. Beach Gattman, Elkhart, 13th District.

Other men welcomed to the Board functions were two men elected alternate trustee: Dr. Edgar E. Cantwell, Vincennes, 2nd District; and Dr. Franklin A. Bryan, Fort Wayne, 12th District. Four previous alternate trustees had been re-elected in 1974 and were welcomed back: Dr. Thomas Neathamer, 3rd District; Dr. Donald C. McCallum, Indianapolis, 7th District; Dr. Max N. Hoffman, Covington, 9th District; Dr. Lloyd L. Hill, Peru, 11th District.

The business of the organizational meeting of the Board was then carried out, with the election of the chairman being the first order of business. The meeting was opened by President Wilhelmus, chairing the meeting temporarily. Ballots were passed out and the election was concluded with Dr. Richard Ingram, Montpelier, 8th District, being elected chairman of the Board.

Further business included the election of two members to the Executive Committee of the Board. These members were Dr. Donald Kerr, Bedford, re-elected; and Dr. William Clark, Fort Wayne, reelected.

That concluded the business of the organizational meeting of the Board and the meeting was adjourned.

ASSETS		6/30/75	9/30/74
GENERAL FUND:			
Cash on deposit		\$ 54,434	\$ 171,535
Investments—at cost:			
U.S. Treasury Bonds—long term		55,135	55,135
U.S. Treasury Bills—short term		409,471	186,936
Mutual Fund shares		—	32,140
Accounts receivable		14,615	28,449
Prepaid expense		10,848	26,092
Office furniture and equipment—net of accumulated depreciation		18,591	20,340
		<u>563,094</u>	<u>520,627</u>
BUILDING FUND:			
Cash on deposit		1,168	2,014
Cash in savings account		7,626	7,309
U.S. Treasury Bills		231,967	205,271
Prepaid expense		1,481	768
Accounts receivable		328	—
Headquarters property			
Land		69,188	69,188
Office building and improvements—net of accumulated depreciation		236,522	243,435
Rental properties—net of accumulated depreciation		75,486	76,919
		<u>623,766</u>	<u>604,904</u>
STUDENT LOAN FUND:			
Cash in savings account		19,190	19,190
Certificates of deposit		20,810	20,810
		<u>40,000</u>	<u>40,000</u>
MEDICAL DEFENSE FUND:			
Cash on deposit		—	931
Cash in savings account		30,406	26,575
U.S. Treasury Bonds—long term		25,078	25,315
		<u>55,484</u>	<u>52,821</u>
		<u>\$1,282,344</u>	<u>\$1,218,352</u>
LIABILITIES AND FUND BALANCES			
GENERAL FUND:			
Accounts payable	\$	24,828	\$ 13,822
Payroll taxes withheld		—	2,110
Accrued taxes		—	615
Dues payable to AMERF		20,563	20,660
Advances from AMA		9,278	9,278
Unearned portion of current year dues		254,546	109,371
Dues restricted to Speaker's Bureau		52,197	41,320
Exhibitors' deposits for annual meeting		400	19,533
Advance from Local Health Survey		—	19,149
Lease contracts payable		1,183	1,427
Fund balance		200,099	283,342
		<u>563,094</u>	<u>520,627</u>
BUILDING FUND:			
Accrued taxes on rental properties		1,886	2,259
Damage deposits and accounts payable		1,046	3,128
Loans from members (non-interest bearing)		20,025	20,275
Fund balance		600,809	579,242
		<u>623,766</u>	<u>604,904</u>
STUDENT LOAN FUND:			
Fund balance		40,000	40,000
		<u>40,000</u>	<u>40,000</u>
MEDICAL DEFENSE FUND:			
Payable to General Fund		951	—
Fund balance		54,533	52,821
		<u>55,484</u>	<u>52,821</u>
		<u>\$1,282,344</u>	<u>\$1,218,352</u>

The next meeting of the Board was called for Sat., Nov. 23, and Sun., Nov. 24, 1974. One of the big problems for action stemmed from the October 1974 meeting of the House of Delegates—consideration of the medical liability insurance problem in the state of Indiana. During the 1974 annual meeting there was a meeting of a special reference committee. This reference committee made specific medical liability recommendations which were adopted by the House of Delegates in the form of the following resolution:

"Resolved, that the House instruct the Board of Trustees to work with a presidentially appointed ad hoc committee to gather information and come forth with recommendations within 30 days to be acted upon definitely at a special open meeting of the Board of Trustees within 60 days; and further, be it resolved, that a dues increase of \$10, payable one time, be marked to fund the publicity and legal activity."

Acting under the direction of this resolution, the Board did schedule the two-day session, Nov. 23-24, with the main item of business the discussion of the medical liability problem. The meeting on Sun., Nov. 24, was attended by the Board and by approximately 120 physician-members—all vitally interested in the crucial question of medical malpractice and insurance coverage.

During the course of the meeting, a Patients' Compensation Act (prepared by Mr. James Stewart, attorney for the Indiana State Medical Association, in conjunction with several Indianapolis attorneys was read and explained to the group. Discussion followed and, on a motion by Dr. Ferrara it was approved that the Patients' Compensation Act would be introduced into the 1975 legislature.

Further business for the day included a continuation of the president's Ad Hoc Committee on Medical Liability, under his direction, for the purpose of investigating alternative solutions to the medical liability problem in Indiana. One suggestion was to search for a carrier who would be willing to write a state-sponsored medical liability program. There was much discussion concerning this and the continuation and power of the ad hoc committee; however, ultimately it was decided that the committee would have the power to interview multiple carriers for the possibility of a state-sponsored plan and, if satisfactory propositions were offered, to present them to the Board for a final decision.

In addition to these two major items of business, a motion was passed to instruct our Speakers' Bureau to include speakers, fully and thoroughly acquainted with the subject of medical liability in Indiana, to address the subject when requested.

There being no further business, the Board adjourned with the next meeting scheduled for January 1975.

The Board convened for a two-day session on Sat., Jan. 18, and Sun., Jan. 19, 1975.

President Wilhelmus announced to the Board that Robert Mahowald, former senator in the state legislature, had been employed as lobbyist for the ISMA and would be working with the Commission on Legislation.

Reporting on insurance coverage possibilities, Dr. William Cast, chairman of the ISMA's Committee on Medical Liability Insurance, told the Board that the committee had heard a proposal for a cooperative plan with ARM Insurance, a federation of 16 independent insurance agencies who have agreed to market cooperatively a product throughout the state of Indiana. Dr. Cast detailed the plan as placed before them and said the ARM group agreed to hear the committee's objections and to return with more firm proposals. On motion of the Board, Dr. Cast's committee report was accepted. Further substance of this committee report stated "that the claims-made concept, which, while an actuarial device for the insurance company, could not be accepted by the medical profession without the presence of control by the Insurance Commissioner, a responsible insurance industry operating in an atmosphere of competition, and without the provisions of contractual guarantee for future coverage at guaranteed premium costs." The committee also submitted a resolution concerning "claims-made" type policies. The Board moved that the Insurance Commissioner of Indiana be informed of adoption of the report and of its substance.

On motion of the Board, Dr. Lowell Steen, Hammond, was supported by the Board in his bid for election as an AMA trustee in June 1975. Alvin J. Haley, M.D. Fort Wayne, and Wei Ping Loh, M.D., Gary, were reelected to the Editorial Board of *The Journal*; and reelected to the Board of the Indiana Medical Education Foundation for two-year terms were Drs. Lester D. Bibler, Indianapolis, and Bernard Hall, Logansport. For three-year terms were Drs. Jack H. Hall, Indianapolis, and Joe Dukes, Dugger. Renominated to the Blue Shield Board were Drs. Wilbert McIntosh and Maurice E. Glock, both for three-year terms, and Peter E. Gutierrez for a two-year term.

Chairman of the Blue Shield Board, Dr. Joe Black, reported on activities of the Board over the past months and complimented the physicians nominated by ISMA for their attendance and interest. Speaking to the financial difficulties of Tel-Med (telephone health information service to the public), he said that Blue Shield would make available

to ISMA \$25,000 plus \$5,000 for additional tapes, updating, etc., to continue operation but that Blue Shield would like to advise a more reasonable financing for the operation. The Board moved (1) to accept the \$25,000 and the additional \$5,000 and (2) that the Tel-Med Committee communicate with Blue Shield to study better utilization.

It was reported to the Board that the AMA would go to court in an attempt to prevent the federal government from implementing the National Health Planning and Resources Development Act, a law replacing the Comprehensive Health Planning Program and the Regional Medical Programs. The Board approved that a letter of commendation be sent to the AMA for this action.

Reporting on further activities by the AMA, Dr. James Harshman, floor leader of the AMA Delegation, said the House approved a \$60 assessment per member for 1975. The ISMA Delegation opposed all of the special assessment motions and also opposed a recommendation, eventually defeated, that the dues be increased by \$90, effective Jan. 1, 1976.

Discussed at great length was the restructuring of ISMA commissions and committees, as posed in the report of the Future Planning Committee. The Committee's recommendations closely parallel the internal council structure of the AMA. Opinion was expressed that the present structure was antiquated and that reducing memberships under the newly proposed plan would not necessarily negate greater participation since subcommittees could be named under each new commission to consider special problems. The Board passed two motions: (1) that the Future Planning Committee report on the commission/committee restructure be referred to the Commission on Constitution and Bylaws for implementation in conference with the Future Planning Committee, and (2) that one member from each district medical society be placed on the each commission.

Also discussed by the Board, as a direct result of efforts of smaller areas to get more physicians, was the subject of fees being lowered for physicians moving from a large urban area. The Board adopted a motion that a request be made to Blue Shield to look into the problem of physician distribution, variances in fees, and the division of the state into two fee areas.

Adopted was a resolution on discrimination, transmitted from the Fort Wayne Medical Society. The resolution read:

"Be it resolved, that the Indiana State Medical Association shall continue to extend to all its members equal protection and that no rights, privileges, or obligations of its members shall be abridged on the basis of

sex, race, color, creed, national origin, or school of medicine."

The meeting was adjourned to convene on Mar. 9, 1975.

At the Mar. 9 meeting, President-elect Vincent Santare reported to the Board that House Bill 1460, Patients' Compensation Act, had passed on second reading before the House of Representatives and that the Medical Practice Act (minus the physician-assistant portion) had passed the third reading in the House.

Two resolutions from Vanderburgh County Medical Society were referred, without recommendation, to the 1975 House of Delegates. One having to do with air travel costs asks that reimbursement be made at tourist or economy rates unless some physical ailment of the traveler makes this inadvisable or in cases of emergency when other accommodations are not available. It also urges the Indiana Delegation to the AMA be instructed to work for the adoption of a similar policy at the AMA level. The resolve of the other resolution states that until such time as the Association's resources permit the luxury of travel and transportation of staff and equipment, all meetings be held in Chicago, except for government-related activities which may be better served by a Washington location. The latter resolution also states that scheduled sessions at distant sites be rescheduled for Chicago unless compelling and persuasive reasons can be advanced with appropriate fiscal data.

Discussed by the Board were automobile insurance company forms asking for medical information about persons over 65 years of age and their capability to drive an automobile. The Board reaffirmed the action of the 1968 House of Delegates in Resolution 68-20B which states that while physicians are "willing to submit data and do appropriate examinations, they believe that questions of driving ability and insurability should rest with the insurance company instead of with the physician." The Board further directed that the 1968 resolution be circulated to the county medical societies and to the Insurance Commissioner of Indiana with a request for a reply from the Insurance Commissioner.

The Board approved appropriate memorial of deceased past presidents at the first meeting of the House following death. The trustee from the deceased president's district is to see that appropriate recognition is planned.

The Board was informed that Winona Memorial Hospital, Indianapolis, had been selected for pilot study under I-MEDIC. The hospital accepted after hearing a presentation of Dr. Peter Petrich and a representative of ROCOM (an Ohio-based computer system) on how such a peer review system would function. The original time for the pilot

study of the effectiveness of a system was set for 90 days; but, on motion of the Board, it was extended for a six-month period. I-MEDIC was referred to as a viable independent alternative to PSRO.

For an appointment to the Judicial Council of the AMA, Dr. Donald E. Wood, Indianapolis, received the Board's support.

Also supported by the Board was the statement of Malcolm C. Todd, M.D., president of the AMA, concerning opposition to new hospital utilization review regulations. Dr. Todd, in announcing the filing of the lawsuit against the Department of HEW, said, "This is the first time we of the American Medical Association have taken legal action against HEW. It may not be the last. We serve notice now that we will oppose every attempt by the government to interfere between a physician and his or her patient."

To carry out the objectives of the Interprofessional Relations Commission action, which arose from current discussions between attorneys and physicians on professional liability, law suits and legislation, the Board discussed expanding the Medical-Legal Review Committee. By an adopted motion the Board requests the House of Delegates, through the Commission on Constitution and By-laws, that the Medical-Legal Review Committee be directed to have minimally three members each from the ISMA and from the State Bar Association.

Health planning regions under Public Law 93-641 were aired by the Board. In a letter to Governor Bowen the Board had pointed out that ISMA had studied a similar proposal in 1965 and that 14 regions, which were then developed, have been since used for health planning and practically all other programs of a similar nature. The letter further pointed out that these regions do not conform to PSRO areas, which were arbitrarily established by HEW. The Board moved that the Governor be advised to develop areas for P.L. 93-641 along the same regional boundaries, or combinations thereof, and that conjoining relationships by counties with other states be avoided because of past unpleasant experiences in early attempts at crossing state boundaries.

The meeting was adjourned to meet again on May 4, 1975.

At the May meeting President Wilhelmus reported that the new Medical Practice Act, minus the physician-assistant portion, had passed and that the Governor had vetoed the foreign physician bill which would have allowed these doctors to practice in Indiana without taking the same examination taken by Indiana University graduates. Discussing H.B. 1460, the Patients' Compensation Act, President Wilhelmus detailed for the Board the inside story of the activities of his special committee. Because of numer-

ous requests from members asking for clarification and guidance, the Board moved that a letter be sent to all members to explain the salient points of the law and the implications on insurance coverages, malpractice suits pending, statute of limitations and other points of concern to the physician. The effective date of the law—July 1, 1975.

Mr. William J. Davey, vice president of the Medical Protective Insurance Company, Fort Wayne, also reported to the Board that his company will be writing more business which will be occurrence policies; and as to why insurance carriers are limited in the number of insureds, he said this is regulated by law, inasmuch as the total premiums received by a company cannot exceed three times its capital structure.

As a result in the passage of H.B. 1460, Dr. Hugh Thatcher, treasurer, reported a \$70,000 deficit in the ISMA budget. The Board moved that the budgetary deficiency be referred to the Board Committee on Economic and Fiscal Affairs and that this committee prepare, if needed, a resolution for the House of Delegates.

Statistical information was presented to the Board by Dr. Steven C. Beering, Dean, Indiana University School of Medicine. Out of a total class of 305, he said there would be 286 Hoosiers starting their freshman year at medical school (preference is given to Indiana's young men and women). There were 812 applications from state students, with the grade average approximately 3.66. Over two-thirds of the students are receiving student aid. He pointed out that 60 percent of the I.U. graduates are staying in Indiana to practice and that this percentage is better than that achieved by any other state in the nation. Commenting on physician-to-population ratio, the Dean said the national average is 160 to 100,000 population. Indiana has a ratio of 105 to 100,000. And, with everything functioning as is projected, by 1982 Indiana would meet the current national average; however, by that time the national average will have also moved ahead.

In continuation of the discussion of health service area designations under P.L. 93-641, Dr. Arvine G. Popplewell, a member of the Board liaison committee on area designations, and Dr. William Paynter, state health commissioner, addressed the Board. Dr. Popplewell said he had pushed for five areas in the state but that Dr. Paynter had stressed the importance of a three-area designation, in that it would minimize the size of the overall state agencies, with only three areas reporting rather than five. Sufficient monies are available to each of three areas to do a fairly complete job and Dr. Paynter is committed to permit subregionalization, with three subregions in each of the major regions,

and is also committed to the assurance of physician input of significant nature in both subregional and regional areas. Asked how the establishment of health-service area administrations would be accomplished, Dr. Paynter said that the Department of Health, Education, and Welfare would assume this activity. He said that the three-region organizational plan had been sent to HEW but presently there are no regulations, no system of Board selection, etc. He said he felt the ISMA should form a consortium of health care providers; i.e., the Dental Association, the Hospital Association, and others, who are concerned with the development of strategy and who would demonstrate an early interest in shaping the plan. HEW, he said, will accept applications from the providers who wish to lead in these regional formations.

In support of Dr. Lowell Steen's candidacy for AMA Trustee at the Atlantic City meeting, the Board approved \$3,000 in support and also authorized the delegation to utilize long distance calls to other delegations requesting support.

The Social Security Administration, Dr. Santare reported, offered to ISMA the option of collecting data on prevailing charges, physician fees and physician specialties. This participation by ISMA was rejected on motion of the Board.

The Board voted to adopt the substance of the policy statement of the Texas Medical Association concerning utilization review. Some of the points are:

- (1) The expense of conducting utilization review programs shall be borne by the company or agency which requires review. Physicians who work in a review capacity shall be appropriately compensated for their services.
- (2) Nonphysician professionals who work in a review capacity shall be responsible to and shall be directed by physicians.
- (3) The Association feels it will best serve the interest of the public, patients, and medical profession if physicians will lend their experience and expertise to the development and management of the system's design into which medical statistical data will be fed.

The meeting adjourned to convene on June 8, 1975.

Gratitude was expressed to Dr. M. O. Scamahorn for his activity and involvement with Reference Committee F in studying the financial picture of the AMA and for the committee's recommendations for revitalizing the fiscal structure.

The Board instructed our delegation to the AMA to oppose all resolutions referring to mandatory relicensure and recertification.

The Board moved that an appropriate memorial plaque be presented at the annual convention of the ISMA to Mrs.

K. O. Neumann, honoring the activity and dedication of Dr. Neumann to the Indiana State Medical Association.

The Indiana Academy of Physicians' Assistants request for a liaison representative from the ISMA Board was approved. President Wilhelmus named Dr. Franklin Bryan as the liaison representative.

The Board went on record opposing claims-made policies and at the same time approved a visitation of the president and representatives of his selection to make a personal call on the president of St. Paul Insurance Company to discuss the company's policy.

For presentation to the ISMA House of Delegates, the Board is to prepare a resolution requesting establishment of a medical examiners' system in Indiana.

Inconsistencies in ISMA-endorsed insurance programs were called to the attention of the Board. Two major medical programs (one through Blue Cross/Blue Shield, and one through CNA, and approved by the Board) are both being carried in some instances by members. The Board moved that the matter be referred to the Commission on Medical Economics and Insurance for review.

Dr. David Crane, chairman of the Commission on Public Information, proposed the utilization of radio spot announcements in conjunction with the Bicentennial celebration. These spots, he said, would be prepared by a member of the ISMA Speakers Bureau (a radio and TV professional announcer) and would contain a credit line to the ISMA. The Board moved this matter be tabled until the August meeting, at which time both this proposal and another medical tape program proposal made to the Marion County Medical Society could be reviewed.

Dr. Eli Goodman, chairman of the Board Committee on Economic and Fiscal Matters, summarized actions of the committee's meeting. The committee has recommended that a budget for next year be ready for the August meeting of the Board. He said the membership in all probability could expect a dues increase.

The meeting adjourned to convene on Aug. 10, 1975.

In conclusion, this has been a year full of major problems for medicine. We have, I believe, had a taste of success in some of our battles; for example, passage of a Medical Malpractice Act, a successful suit by AMA against utilization review regulations, and the passage of a new Medical Practice Act. We have also seen the election of multiple Hoosiers to AMA offices of importance, which will be of great help to ISMA.

We must, however, be careful that we are not lulled into complacency by these successes, because each area mentioned requires constant vigilance and continued work to assure ultimate suc-

cess. We have, as well, other areas of immediate concern to medicine which must be addressed. One such area is PL 93-641, which demands immediate concern by physicians and appropriate action. Another area that I feel is and will continue to be of major concern is the area of data handling. I would hope that ISMA will approach this latter subject with a view to protecting our patients' right to privacy and, secondly, to protect ourselves against misuse or misapplication of stored health data.

It is easy to see that medicine is being bombarded almost daily by encroachments on the practice of medicine in a free enterprise system. These encroachments or attempts at encroachment are from every conceivable source and will necessitate a continuing, aggressive battle by organized medicine to protect our patients' freedoms and ours. We must therefore strengthen our organization and be willing to spend of our time and talents to afford such protection or we will soon be looking back with regret at freedoms lost without a fight.

It has been a pleasure, though no little work, to serve as chairman of the Board of Trustees of ISMA this past year. I wish my successor well and pledge support to him and to ISMA in the difficult times ahead.

RICHARD INGRAM, M.D.
Trustee

First Trustee District

HOUSE ACTION: Ordered filed.



BERNARD B. ROSENBLATT, M.D.
Trustee

The First District Medical Society held its annual meeting on May 8, 1975, at the Rolling Hills Country Club, Evansville, with 120 persons present. Mead Johnson and Company hosted the social hour. The speaker for the evening, the Rev. Tom Mullen, Associate Dean at Earlham College, Richmond, gave a very interesting and entertaining program.

Gilbert M. Wilhelmus, M.D., president of the Indiana State Medical Association, commented on the new professional liability insurance bill, another bill which proposed to permit foreign medical graduates to be licensed to practice medicine in Indiana after a two-year preceptorship without taking the examination required of American-trained physicians, and the new Medical Practices Act. He also reported on a meeting with the Indiana congressional delegation in Washington, D.C.

Dr. Rosenblatt then presented a report, and noted particularly that the new

Medical Practices Act includes a definition of the terms "physician" and "practice of medicine" in such a way that these cannot be used by chiropractors or others who are not medical doctors. He remarked that a medical doctor must, under terms of the act, be a citizen of the United States or in the process of obtaining citizenship. A new board is also created which has broad powers to discipline physicians. Dr. Rosenblatt mentioned that the ISMA Board of Trustees during the past year has dealt with questions involving health planning, peer review and the usual problems of financing. He also pointed out that ISMA has a very active speaker's bureau which makes lay speakers available to talk in any part of the state on medicine and politics. Finally, Dr. Rosenblatt asked those at the meeting to stand in recognition of Dr. Wilhelmus for his outstanding and successful efforts to insure passage of legislation which would relieve the professional liability insurance problem. *It was officially moved that recognition of Dr. Wilhelmus be included in the minutes, and this action was duly recorded.*

Albert S. Ritz, M.D., First District president, called the attention of those present to the fact that it was the Vanderburgh County Medical Society Board of Directors which originally approved a resolution calling for a redefinition of the term "physician"; this resolution was forwarded to ISMA and adopted by them.

Ralph F. Carlson, M.D., First District trustee on the Board of Indiana Blue Shield, reported that all physicians in the state recently received a questionnaire asking their opinion of certain surgical procedures being carried out in medical offices. He remarked that early returns indicate there is much interest in this possibility and it may be that Blue Shield will review its reimbursement policy to see whether such procedures should be covered at less cost than is necessary when they are carried out in the hospital. Dr. Carlson introduced Mr. Gary Miller, Director of Provider Relations for Blue Shield. Also introduced were Ms. Beverly McGraw, Blue Shield Field Representative for the area, and Mr. Phil Sizelove, Senior Consultant for Blue Shield.

In its final action the membership elected Martin J. Bender, M.D., president of the First District for 1975-76, John H. Barrow, M.D. vice-president and Herman F. Rusche, M.D. secretary-treasurer.
BERNARD B. ROSENBLATT, M.D.,
Trustee

Second Trustee District

HOUSE ACTION: Ordered filed.



PAUL W. HOLTZMAN, M.D.
Trustee

This has been a year of enlightenment, service, and reward.

We have been enlightened by the fact that doctors work together when their pocketbooks are threatened. We have been enlightened by the fact that we have in limbo vast young talents who can rise to an occasion with vigor, eagerness, and enthusiasm. We have been enlightened by the fact that, in spite of being in a profession which has lost some of its prestige by the actions of a few, we still have clout both as individual doctors and as an organization.

The service of the delegated few has been expanded to include interested doctors who now attend their respective society meetings and are anxious about the changing times. Time in service is still wanting, but many have contributed dollars to expand the cause. Here again, the youth of our organization have come forth with tremendous effort in service for the good of the Indiana State Medical Association.

Our rewards to date include, of course, the passage of House Bill 1460. But more importantly, our reward has been the restatement by the people of their confidence in the medical profession. Organized medicine is being revitalized.

I compliment all of those whose diligence and interest is reawakening our association to its importance.

Without fighters there can be no battle and without battles there can be no victories.

PAUL W. HOLTZMAN, M.D.,
Trustee

Third Trustee District

HOUSE ACTION: Ordered filed.



ELI GOODMAN, M.D.
Trustee

The 1974 Annual Meeting of the Third District Medical Society was a combined meeting with the Third District of the Indiana Academy of Family Practice.

The meeting was held Sept. 14-15 at the Marriott Resort Center, Clarksville.

President Claude J. Meyer, M.D., presided and was reelected to that office. Dr. Charles McCalla of Paoli was elected

secretary to succeed Dr. Robert K. McKechnie.

Dr. Thomas Neatham was reelected alternate trustee and Dr. John Paris was renominated to the Blue Shield Board of Trustees.

The scientific program was sponsored by Wyeth Company and was given by Dr. and Mrs. Edgar Stuntz of Purdue University.

A dinner dance on Saturday night was followed by a "Bloody Mary" brunch on Sunday morning. The state association was represented by a contingent including staff and headed by Board Chairman Vincent Santare.

Golf, swimming and water sports were available to all those who desired.

It was decided during a brief Sunday morning business meeting to hold the 1975 meeting at the same location, the Marriott Resort Center, Clarksville, Indiana, and the 1976 meeting at the Sheraton resort at French Lick.

ELI GOODMAN, M.D.
Trustee

Fourth Trustee District

HOUSE ACTION: Ordered filed.



HOWARD C. JACKSON, M.D.
Trustee

The annual meeting of the Fourth District Medical Society was held at the Hillcrest Country Club, Batesville, June 4, 1975. Elections were held during the business meeting which began at 4:00 p.m. Dr. Robert Acher, Greensburg, was elected president, Dr. Ivan Lindgren of Aurora was elected vice-president, and Dr. Alvin Henry was re-elected our Board Member to Blue Shield.

The 1976 Fourth District Medical Society will be hosted by Decatur County at Greensburg on an as yet undetermined date. The afternoon scientific session was well organized, well presented and well received. President Wilhelmus spoke at the evening dinner regarding medical liability and the Patient's Compensation Act. We are indebted to Dr. Wilhelmus, the ad hoc Professional Liability Insurance Committee, and the Indiana Medical Foundation for their efforts in securing passage of this important landmark act. Dr. Everett Bickers, Floyd Knobs, alternate delegate to the AMA, was present at our evening meeting and spoke regarding AMA matters.

Unfortunately, all we wished for was not granted by the 1975 Legislature. The next year may see many changes and, hopefully, answers to our questions about our Act and about its effect on availability of insurance, its structure, its

cost, about our apparent, and about our eventual liability. We congratulate Dr. Wilhelmus, the committee, the Foundation and all the Indiana and Fourth District physicians who worked hard for the passage of this Act. It was truly a team effort.

Health Service Agencies took over where Professional Standards Review Organizations left off as our second most pressing concern. 1975 and 1976 will see many changes in how we adjust, adapt and organize in the face of yet another threat to the private practice of medicine. "Forbes" magazine in its July 15, 1975, issue, states: "The day of self-policing is probably past." "Forbes" quotes AMA executive vice-president Dr. James Sammons, "Of all the bills they've ever passed short of declaring war, this is the most dangerous. It vests decision making power in the hands of totally unprepared people." I would agree that this is the most dangerous bill but it seems all too evident to me that the health planners, local Comprehensive Health Planning executives, misguided physicians and anti-doctor lay people are all too prepared and eager to wield the decision making and regulatory power in the Health Planning and Resources Development Act of 1974—P.L. 93-641.

HOWARD C. JACKSON, M.D.,
Trustee

Fifth Trustee District

HOUSE ACTION: Ordered filed.



C. M. SCHAUWECKER,
M.D.
Trustee

The outstanding event of this past year, in my opinion, was the solidarity of the membership of the ISMA in their successful effort in getting professional liability insurance legislation passed. The leadership was magnificent. One cannot help but wonder just what might be accomplished on the national level if all physicians united behind the AMA and worked together just as hard for those causes we know to be just, and against those who would destroy the very principles that made American medicine the finest in the world. The idea is thought-provoking, isn't it?

The Fifth District held its annual meeting at the Holiday Inn at Terre Haute on May 14th. The business meeting was exceptionally well attended, with Mr. Robert Amick representing the ISMA and Mr. Gary Miller representing Blue Cross. Two past presidents of the ISMA were also present: Dr. Joe Dukes of Dugger, and Dr. Malachi Topping, Terre Haute. The business meeting was conducted by President Paul Humphrey,

Terre Haute, and there was considerable discussion concerning the recently passed malpractice act. It was also noted that several physicians had received notices of a marked increase in their malpractice insurance premiums, with no relationship to past or present litigation. Simply a blanket outlandish increase, and it is apparently statewide. Some expressed the view that ISMA should give considerable study to starting its own insurance company; others thought that the recently enacted law should be given a chance to work, and perhaps such a major step might not prove to be necessary.

The election of officers was held and the new officers for the Fifth District are as follows: Dr. Robert Oehler, Brazil, was elected president; Dr. Nancy Oehler, Brazil, was elected secretary-treasurer. The meeting next year will be held at Brazil.

Also elected was Dr. Edward Johnson, Terre Haute, to fill the unexpired term of Dr. Fred Dierdorf, Terre Haute, as Blue Cross representative. Dr. Dierdorf is moving to Florida. Also, Dr. Cleon Schauwecker, Greencastle, was reelected trustee of the Fifth District.

After the dinner, Mr. Temple Spencer gave a very thought-provoking talk concerning the good and bad sides of the medical profession, as well as the country as a whole. The talk was very well received.

C. M. SCHAUWECKER, M.D.,
Trustee

Sixth Trustee District

HOUSE ACTION: Ordered filed.



PAUL M. INLOW, M.D.
Trustee

I will not be the only Trustee to make the observation that when physicians have a common goal and stand united we can initiate change to improve the practice of medicine. I urge the physicians of the Sixth District and state to become active and stay active in their support of ISMA.

The Sixth District meeting was held at Richmond on May 15th, when we had the opportunity to tour the new facilities at Reid Memorial Hospital. The afternoon speaker was William Murray, M.D., Indiana Director of Mental Health, whose topic was "The Current Status of State Hospitals and Comprehensive Mental Health Centers."

Our state president, Dr. Wilhelmus, was a very welcome guest. He gave an update on Bill #1460 as passed, and his feelings and advice on how this legislation will affect our practice.

The president of the Sixth District, Dr. Davis Ellis, presided at the business meeting. Dr. Glen Ward Lee was reelected alternate trustee. The new officers are Dr. William Kerigan, President, Dr. C. G. Clarkson, Vice President; and the Secretary-Treasurer is to be elected by the Henry County Medical Society.

The dinner was held at Forest Hills Country Club. Our speaker was Joseph Cloud, the director of the Indiana Department of Natural Resources. He talked about and showed slides of the state parks, recreational facilities, forests, reservoirs and wildlife preserves.

P. M. INLOW, M.D.,
Trustee

Seventh Trustee District

HOUSE ACTION: Ordered filed.



JOSEPH F. FERRARA,
M.D.
Trustee

IN UNITY THERE IS STRENGTH

In the minutes of the June ISMA Executive Committee Meeting special note was taken of the decline in the membership in ISMA and AMA.

To those who stand on sidelines and do not give of themselves, do not give service, do not participate, do not attend important meetings but just sit on the sidelines and gripe, find fault and say "Why don't they do this or that?" my suggestion is: Participate, get active, join the effort rather than resign, and correct deficiencies you complain of—if there are any.

Decisions will have to be made with or without you. By participating, one has the voice, can be heard, and one might be surprised that "little you" influenced the course of events.

In the ISMA and down through the county societies, no officer receives any salary. There may be remunerations that do not cover actual expense, but that is all.

Unless one has medical political aspirations there is no future in the offices—no recompense except for a sense of gratification from contributing, participating and correcting or finding solutions to some of the problems affecting the practice of medicine.

ISMA has achieved considerably in the past year and deserves the support and participation of the individual members of the medical profession.

Just recently the ISMA reminded me of a family with its infighting but against an "outsider" the members united. For example, in the tough decision whether to oppose claims-made insurance and, in so doing, knowing that some members

would be hurt, one factor that influenced the final decision was that many of the ISMA membership volunteered to make contributions, pay higher dues, pay higher premiums, or help in any way to help their fellow practitioners who might be hurt by the decision to oppose claims-made insurance. This made the heavy burden of making an important and crucial decision a little more bearable.

House Bill 1460, though not perfect by any means, was a great achievement and a good example of the medical profession unifying for a common cause.

One suggestion to stimulate, create interest, and participation of the membership is that the ISMA Board and House of Delegates should make some restriction on the number of high offices one individual can hold at any one time. There is not one of us who is indispensable, not one of us has all the brains, so why not spread the offices to deserving members, thus spreading participation and possibly inducing more interested competent individuals to take active part in ISMA functions and determine its policies.

In creating interest we stimulate participation. Through participation we might stimulate unity and in unity there is strength—the strength needed to overcome some of the obstacles facing the medical profession. So, let's all pitch in and help.

JOSEPH F. FERRARA, M.D.,
Trustee

Eighth Trustee District

HOUSE ACTION: Ordered filed.



RICHARD
INGRAM, M.D.
Trustee

The Eighth District Medical Society met at the Portland Country Club on June 4, with approximately 20 members and their guests on hand for the business meeting.

The District concerned itself with the Health Service Areas, discussion of the new Medical Practice Act and the Medical Liability Bill.

The district adopted a resolution expressing its appreciation to Dr. Richard G. Ingram for the many years of service he has given to the district.

Officers elected were Dr. Jack M. Walker of Muncie as Trustee to succeed Doctor Ingram. Dr. Joseph Gahimer of Anderson was elected president and Dr. James A. Moneyhun of Anderson was elected secretary-treasurer.

The location and date of the 1976 meeting will be given later.

RICHARD G. INGRAM, M.D.
Trustee

Ninth Trustee District

HOUSE ACTION: Ordered filed.



WILLIAM M.
SHOLTY, M.D.
Trustee

This year has been one of great activity and accomplishment for the Board of Trustees and the ISMA as a whole. We all can take pride in the Indiana legislature passing the new Medical Practice Act and the Patient's Compensation Act. Indiana was a pioneer in patients compensation field of legislation. We feel that these acts will solve many of medicine's problems.

Just when we thought that everything was all set and no great problems were pending, the St. Paul Fire and Marine Insurance Company insisted on issuing only a claims-made type of malpractice policy. The Board of Trustees, after careful deliberation, numerous meetings and telephone conferences, unanimously recommended to the state insurance commissioner that he not sanction the claims-made type in Indiana.

The 9th District Meeting was held at the Curtis Creek Country Club in Rensselaer on June 12. The Jasper and Newton Medical Societies were host. Dr. Arthur Schoonveld presided. Dr. Kenneth Ahler was secretary-treasurer. ISMA President-elect Dr. Vincent Santare gave a report on the medical malpractice situation. Dr. Peter Petrich introduced Judy Griffin and Bill Sizemore, Blue Shield field representatives. He then reported on Blue Shield procedures and the AMA delegation activities.

Dr. Max Hoffman reported on the 1975 ISMA Convention Planning Commission. Reports of the work of various commissions were given by Drs. John Knote, Kenneth Ahler, William Ferguson, Bruce Work and Robert Vermilya. The Trustee in this report discussed the need for physician assistant legislation. This portion was removed from the Medical Practice Act.

He also reported on the great use of the Tel-Med tapes and his frustration in trying to raise funds for its support. A resolution was passed recommending a \$25 increase in ISMA dues specifically to support the Tel-Med program.

The Trustee also reported on the progress of the Indiana Medical Museum and a resolution was passed for ISMA to provide \$2.50 per ISMA member per year for support of this project.

The program, following a fine well-attended banquet, was an address given by Governor Otis Bowen. Next year's meeting location was discussed. The location is to be worked out by the Trustee, field representative and the host

county, which is to be Tipton County.
WILLIAM M. SHOLTY, M.D.,
Trustee

Tenth Trustee District

HOUSE ACTION: Ordered filed.



MARTIN J.
O'NEILL, M.D.
Trustee

Officers elected at the last annual meeting of the Tenth Trustee District, held Sept. 24, 1974, at Valparaiso Country Club were Dr. J. M. Sierkierski, Griffith, president; Dr. J. R. Brown, Valparaiso, secretary-treasurer; Dr. M. J. O'Neill, Valparaiso, trustee, and Dr. Leonard W. Neal, Munster, alternate trustee. The meeting was conducted by Dr. Mario Mansueto, outgoing president, and Dr. Vincent J. Santare, outgoing trustee. There was a golf tournament with prizes awarded to the winners, and a guest speaker, Dr. George W. Crane, who spoke at the ladies' meeting in the afternoon and again at the dinner meeting.

Dr. Santare reported on State Association activities, covering the 1974 House of Delegates meeting. State Association effort to organize a group malpractice program, PSRO, including I-Medic Program, Tel-Med, ISMA headquarters staff shortages, and the existing inadequate dues structure in the State Association.

Guests present were Dr. Peter Petrich, Dr. Malcolm Scamahorn, both past presidents of ISMA, Mr. Stan Tope of Indiana Blue Shield, Blue Shield board members, Dr. Peter Gutierrez and Dr. William Fitzpatrick, and Foundation Executive Secretary Charles Shoemaker.

Officers serving the Lake County Medical Society this year are Dr. Walfred (Chuck) Nelson, president; Dr. David Ross, Gary, vice-president, and Dr. Thomas Gehring, Merrillville, secretary.

In Porter County Dr. Leon Armalavage is president and Dr. Frank Sturdevant is secretary. Both are of Valparaiso.

The outstanding event in the Tenth District this year was the election of Dr. Vincent Santare, Munster, president-elect of the ISMA, at the 125th annual convention in October 1974. Dr. Santare has represented the Tenth District as trustee since 1968 and served as chairman of the Board of Trustees during the 1973-74 term.

Second to this, of course, was the election of Dr. Lowell Steen, Whiting, former ISMA President, to the Board of Trustees of the American Medical Association in June 1975.

The Calumet Foundation for Medical

Care has been active during the year and has established a well developed peer review program. Having been given a planning grant for PSRO activity, the Foundation has developed a new organization, CAPRO (Calumet Area Professional Review Organization) that encompasses Lake, Porter and LaPorte counties, with membership of approximately 71% of the doctors in this area and is getting closer to its goal of becoming a Conditional PSRO in Indiana Area I.

Members of both Lake and Porter County Medical Societies were very active during the campaign for medical liability legislation and contributed a great amount of time and money in the successful attempt to get legislation passed. The members are grateful to the legislators of the area and are inviting them and their wives to the next annual meeting of the Tenth District in September 1975. There was good support, also, for the Medical Practice Act.

There have been several meetings concerning the National Health Planning and Resources Development Act of 1974. There was disapproval by both counties of the decision to divide the state into three geographic areas and the reasons for disapproval are very legitimate. An effort is being made to cooperate with the other counties across the north part of the state in developing an organization to implement this law.

Porter County continues its Charitable Trust Program and has received recognition for this meritorious service from other counties and states.

The next annual meeting will be held Sept. 24, 1975, at the Valparaiso Country Club. An alternate trustee and a Blue Shield board member will be elected at this time.

MARTIN J. O'NEILL, M.D.,
Trustee

Eleventh Trustee District

HOUSE ACTION: Ordered filed.



JAMES A.
HARSHMAN, M.D.
Trustee

Since last October the physicians of the state and the ISMA, through its officers and Board of Trustees, have been confronted with the most severe problem that the profession has ever faced, professional liability insurance. Through the united effort of all physicians remedial legislation was enacted by the Indiana General Assembly. Although its test of constitutionality is yet to come, we have every reason to believe the bill will withstand the test. Even though H.B. 1460 was not a perfect

piece of legislation, it did correct many of the inequities that existed under the old statutes. Further amendments might be necessary. All physicians are deeply grateful to our president, Dr. Wilhelmus; to Dr. Bill Cast and Dr. Paul Muller; to our legal counsel, Mr. James Stuart, Mr. Dick Guthrie, and Mr. Fred Garver, and to our own association administrative staff for their accomplishment.

While the fires still rage on the front burner, smaller flames have broken out on the back burner at the federal level. The AMA has taken the federal government to court for the first time in its history and has won a temporary injunction on the implementation of the UR regulations. Public Law 93-641, the National Health Planning and Resources Development Act of 1974, has been enacted by Congress. This bill has far reaching implications and establishes "mini-HEWs" in each state. Three are proposed for Indiana. In June 1975 the AMA House of Delegates instructed the AMA Board of Trustees to take any action, including legal action, they deem appropriate and effective to prevent the implementation of PL 93-641.

Other organizations are frustrated by attempts of the federal government to control the health care delivery system and are seeking relief from these actions by bringing suit against HEW. The Association of American Medical Colleges filed a suit which asked that the revised schedule of limits on hospital inpatient routine service costs be declared illegal and invalid. AHA has filed suit to stop the federal government from eliminating the 8.5% Medicare nursing cost differential given to offset the extra cost of aged patient care. The JCAH filed suit for a permanent injunction barring HEW from further public disclosure of JCAH survey documents.

In the past, organized medicine's efforts in Washington were totally directed at lobbying. It is clearly apparent that much of our effort must also be directed at seeking legal redress in court to protect the best interests of our patients and their physicians.

In order that we as an association can respond quickly to the issues that face us, a reorganization of our committee and commission structure is imperative. The machinery of yesteryear needs redesigning to handle the problems of the 70s. If ISMA is to survive and represent the practicing physicians in years to come, "corrective surgery" will be needed. It can not come too soon. Lost motion on the trivia will have to be eliminated in order that we may concentrate our efforts on the major issues that face us. Priorities and goals must be established. Our leadership must foresee problems before they become crises, in order that solutions and their alternatives can be worked out.

Last September, Cass County was the host for the 11th District Medical Society in Logansport. The meeting was well attended. Mr. Stanton Evans was guest speaker. Dr. George Wagoner of Delphi was elected president and Dr. Fred Poehler of LaFontaine was reelected secretary of the District Society. Dr. Lloyd Hill of Peru was reelected alternate trustee, and Dr. Don Wagoner of Burlington was elected to the Board of Directors of Blue Shield. The next district meeting will be held on Sept. 17, 1975 in Delphi. Carroll County will be host.

JAMES A. HARSHMAN, M.D.,
Trustee

Twelfth Trustee District

HOUSE ACTION: Ordered filed.



ALVIN J. HALEY, M.D.
Trustee

This year's 12th District officers were: President, Robert Edwards, M.D.; vice-president, Karl Schladerman, M.D.; secretary-treasurer, Tom Felger, M.D.; alternate trustee, Franklin A. Bryan, M.D.; Blue Shield representative, Kenneth Isenogle, M.D.; Blue Shield board member, Maurice Glock, M.D. I, Alvin J. Haley, M.D., am your trustee.

Our annual meeting was held Sept. 11 at the Fort Wayne Ramada Inn and featured a business meeting with reports and discussions. Wives were entertained by Nedra Feeley, doctors and wives were enlightendly entertained and informed about the energy crisis by Professor Hans Heinrich of Heidelberg College (Germany) and the Argonne National Laboratories.

Malpractice insurance was the issue claiming most of the ISMA's attention this year. Much of our time, money and energy went into the effort which culminated in a bill passed by our state legislature to become a standard for other states to emulate.

Great as our efforts were and fortunate as the outcome was with the Patient's Compensation Act, the malpractice problem will not go away. Malpractice premiums still escalate, St. Paul refuses to offer "occurrence" insurance, the Act is headed for constitutional testing in court.

The ISMA is currently considering offering a CNA malpractice coverage for its members.

Farsightedly, the Patient's Compensation Act creates a continuing commission to wrestle with the problem.

Other old and new national problems seem to be at this stage presently:

1. Utilization review regulations are temporarily (perhaps permanently!) stalled by the AMA's court action.

2. Court action to declare PSRO unconstitutional failed but it is languishing because of short funding.

3. The AMA is taking court action against MAC (Maximum Allowable Cost) drug regulations.

4. The AMA seems to be revitalizing itself but needs a whopping dues increase to regain financial stability.

5. The ISMA is considering the Blue Cross-Blue Shield Individual Practice Association concept (sort of a floating HMO).

The ISMA 12th District has introduced resolutions on the following subjects:

1. Calling for equal opportunities for all ISMA members regardless of race, color, or creed.

2. Opposing PSRO and prohibiting cooperation with PSRO.

3. Opposing PSRO but allowing cooperation because "it is the law of the land."

4. Granting Larry Pickering, executive director of the Fort Wayne Medical Society, honorary membership in the ISMA.

5. Calling on the State Board of Health to allow more local latitude to meet health care needs—despite the bureaucracy of the health planning councils and the health service agencies.

6. Various resolutions calling upon third parties to offer better patient and physician services while interfering less with the patient-physician relationship.

During the year I have found the ISMA Board of Trustees individually and collectively diligent and intelligent, agonizing over its decisions because occasionally a few members had to be hurt to help the vast majority of members. Primary attention was given to helping our members deliver the best possible health care to all Hoosiers. Views so divergent as to encompass the entire membership were painstakingly hammered into a consensus.

The other trustees and I are looking forward to another year of facing, enumerating and prioritizing your problems, proposing and evaluating solutions, and judging which solution has the best prospect for succeeding.

ALVIN J. HALEY, M.D.
Trustee

Thirteenth Trustee District

HOUSE ACTION: Ordered filed.



G. BEACH GATTMAN,
M.D.
Trustee

The 13th District Medical Society held its annual meeting at Elkhart on Sept. 12, 1974, at the Elcona Country Club. The annual golf tournament and tennis tournament preceded the business meeting. The business meeting was conducted by Dr. Jack Hannah, Elkhart. For the last two years, we have had an increase in attendance at our business meeting which, I hope, reflects an increased awareness and concern by our members in the affairs of our district and the ISMA. Along with the usual district reports, the commission members gave reports on their activities. The trustee report highlighted the actions of the Board of Trustees for the year 1973-74.

Election was held. Dr. John Hildenbrand, Jr., South Bend, was elected president, Dr. John Luce, Michigan City, president-elect, Dr. David Spalding, Mishawaka, secretary-treasurer, and Dr. G. Beach Gattman was reelected trustee of the 13th District.

Following the business meeting, a discussion on insurance was presented and some of the problems on malpractice insurance were aired. A number of guests were present, including Governor Otis R. Bowen, Dr. Bowen's wife Beth, Dr. Joseph Dukes, Dr. Vincent Santare, Mr. James Waggener, Mr. Howard Grindstaff, and Mr. Herb Dixon of Blue Shield. The business meeting was followed by a banquet which was quite a lively affair with strolling musicians and artists painting a picture of a scene upside down. Following the banquet a play was presented. A good time was had by all.

G. BEACH GATTMAN, M.D.,
Trustee

Editor of THE JOURNAL

HOUSE ACTION: Ordered filed. Doctor Ramsey amended the printed report by stating the deficit of \$34,000 which was expected was \$2,300 less.

THE JOURNAL budget for this year was predicated on an increase in printing costs, postage and a necessary adjustment of salaries. The cost of paper, ink and printers' wages controls the printing bill. Inflation of the cost of living controls the salaries and affects postage rates.

The budget estimate for printing this year was \$10,000 above that for 1974. The budget figure for personnel was about \$4,300 above 1974. The average cost of mailing one copy of our journal has risen 37% in the past two years. Other expense items varied between the two years, some plus, some minus, to almost balance each other. Art work was budgeted for \$1,000 less this year. These changes amounted to about \$14,000, to raise the predicted expenses from \$86,000 in 1974 to \$100,000 in 1975.

The income expected for this year

was almost the same as for 1974. The allocation from dues was listed as an increase, as was the income from local advertising, journal reprints, senior member subscriptions and sale of Rosters and Yearbooks. National advertising revenue was expected to be down, as compared to 1974, by a few thousand dollars.

Expected receipts for both years was in the neighborhood of \$59,000. The deficit for 1974 was forecast as some \$27,000, actually came to \$29,000. The forecast for this year was a deficit of about \$42,000. At the time this report is written the estimate of this year's deficit is about \$45,000. This differs from the forecast principally because the printing bill exceeded the estimate by \$3,500 and the revenue has been down by \$2,000. All figures in this report are rounded.

The supply of good scientific articles has been adequate. In fact, when the smaller issues are considered, our supply of articles has become too large. The "Seminars from Riley Children's Hospital" series, which was organized and nurtured by Dr. Joseph Fitzgerald with a view of a short article almost monthly, has, by necessity, been curtailed.

In addition to the usual special issues on cardiology and Roster, the January issue was devoted to malpractice. The "Electrocardiogram of the Month" has been reinstated under the direction of Dr. John C. Bailey. Dr. William F. Dugan, Jr., contributes the "Cancer Corner" each month. The May issue highlighted the Wells County Medical Society Fall Conference of 1974 which was presented especially to honor Dr. Harold D. Caylor and Dr. Truman E. Caylor.

Plans are being made to reduce the size of THE JOURNAL still further to lessen the difference between income and outgo.

FRANK B. RAMSEY, M.D.
Editor

Delegates to AMA

HOUSE ACTION: Ordered filed.

The Indiana delegation to the American Medical Association successfully placed two men in top posts during the 124th Annual Convention of the AMA in Atlantic City, June 15 through 19, 1975.

Lowell H. Steen, M.D., Hammond, was elected to the office of trustee, and Patrick J.V. Corcoran, M.D., Evansville, was elected a member of the AMA Council on Medical Education.

The delegation participated in the review and study of more than 150 resolutions and reports during the five-day meeting and caucused two and three times a day to go over these reports and plan actions on the floor of the House.

Max H. Parrott, M.D., Portland, Ore., was installed as the AMA's 130th president. Richard E. Palmer, M.D., Alexan-

dria, Va., was named president-elect, and George W. Slagle, M.D., Battle Creek, Mich., was elected vice president. Re-elected by acclamation were Tom E. Nesbitt, M.D., Nashville, Tenn., as speaker of the House, and William Y. Rial, M.D., Swarthmore, Pa., vice-speaker.

The House of Delegates voted to raise dues to \$250 annually for regular members and to \$35 for interns and residents, effective January 1, 1976. Dues for medical student members will remain at \$15. The dues increase is designed to bring the AMA's liquidity reserves to \$27,200,000 in 1977. It will enable the AMA to continue activities at the present dollar level while restoring some programs and initiating new activities to the extent of \$2 million a year for the next few years. The House also urged state, county and specialty societies to conduct a campaign to achieve 100% participation in the \$60 special assessment that was voted by the House at the 1974 Clinical Convention.

In its deliberations on the financial situation, the House worked with reports from its Special Committee, formed at the 1974 Clinical, and with background and statistical reports from the Board of Trustees and the auditors. Dr. Malcolm O. Scamahorn, Pittsboro, served on the Special Committee.

A number of fiscal recommendations made by the Special Committee of the House were adopted, including the apertural affairs to maintain liaison between the House and the Board and to report at the 1975 Clinical Convention. The House also reaffirmed a financial policy of a balanced budget with adequate reserves, recommended presentation of accounting and program budgets in simplified formats, and recommended an annual review and report by the Board on the dues level necessary to support the Association's activities.

The House endorsed the concept of restructuring the AMA and adopted the Special Committee's recommendation that the Council on Long Range Planning and Development prepare a plan to implement structural and operational changes. The report will be submitted at the 1975 Clinical. The House voted to continue on an inactive status the councils and committees proposed for discontinuance last fall, with the members to be used as ad hoc consultants as determined by the Board pending the report of the Council. It also voted that no other changes in the permanent council and committee structure be made pending the report.

The House gave full discussion to AMA publications and recommended to the Board that *JAMA* and *American Medical News* receive resources to keep them at the highest levels and that *Prism* be discontinued. The House authorized the Board to place all publications except

JAMA and *AM News* on a subscription basis for members. It amended the by-laws to remove *Today's Health* as a membership benefit. The House recommended that subscription rates for the specialty journals be designed to make the publications self-supporting and that the number of issues of any AMA publication be reduced as an economy measure if necessary. It endorsed a policy of aggressive advertising promotion and asked the Board to implement the policy as soon as possible.

A Board report on progress toward establishment of an AMA professional liability reinsurance facility was received favorably by the House. It voted to form the reinsurance company and make it operational as soon as possible. The facility would require the participation of five state society captive companies with a minimum of \$12 million in annual premiums and AMA capitalization of \$1.5 million. The House also suggested that state societies consider using voluntary arbitration in conjunction with the American Arbitration Association and the American Hospital Association, or other mechanisms consistent with state laws, for proposed professional liability insurance legislation.

The House commended the Board for its "forthright action" in securing a preliminary injunction blocking implementation of HEW's utilization review regulations. It supported further action to protect the constitutional rights of patients and physicians and urged physicians, through their hospital medical staff committees, "to continue to perform peer review directed at increasing the quality of patient care and reducing its cost." The House voted support of the Board in action, including legal action, to prevent the implementation of the National Health Planning and Resources Development Act of 1974. It also voted support to the Board "in continuing to pursue every possible action" opposing some provisions of the manpower bills and in its commitment "to pursue every avenue of legitimate persuasion and available legal action" on the regulations limiting reimbursement of physicians' fees under Medicare.

In his inaugural address, President Max H. Parrott, M.D., said continued quality of care is the basic picture that must emerge from "today's picture puzzle of medical and health-care issues." In light of government regulation of medical care, Dr. Parrott cited the need for a strong AMA to preserve the quality of care. To give the AMA the capacity for effective action, he recommended that the offices of AMA vice president, president, president-elect, and immediate past president be abolished, that the speaker and vice speaker of the House of Delegates be given votes on the Board of Trustees, and that the chairman of the Board be elected

directly by the House after nomination by the Board. "Hence," Dr. Parrott said, "the chief leaders and chief spokesmen of the AMA would be the Board chairman, acting for the elected officers and the House, and the executive vice president, acting for staff."

"Future Shock" has hit the AMA, said Malcolm C. Todd, M.D., immediate past president of the AMA, in his address at the opening session of the AMA's House of Delegates. The greatest shock waves, Dr. Todd said, are coming from the professional liability issue, but he emphasized that other areas, including clinical medicine, socioeconomics, national politics and the future, also demand AMA attention. Dr. Todd reiterated his suggestion for a university without walls for continuing education, to "lend a new image and a new prestige to continuing education." He urged the AMA to play a major role in the implementation of a new study, similar to the Flexner study, to determine whether the educational process is meeting the need for appropriate training of physicians.

PATRICK J. V. CORCORAN, M.D.
LOWELL H. STEEN, M.D.
JAMES A. HARSHMAN, M.D.
JOHN O. BUTLER, M.D.
MALCOLM O. SCAMAHORN, M.D.
Delegates

THOMAS C. TYRRELL, M.D.
PETER R. PETRICH, M.D.
GEORGE T. LUKEMEYER, M.D.
ROSS L. EGGER, M.D.
EVERETT E. BICKERS, M.D.
Alternates

Reports of Committees

Executive Committee

HOUSE ACTION: Ordered filed.

The Executive Committee met immediately following the organizational meeting of the Board of Trustees on Oct. 8, 1974, for the purpose of organizing the committee. By secret ballot, Dr. Donald M. Kerr was elected chairman. The other routine matters of business were dispensed with and, there being no further business, the committee adjourned to meet again on Nov. 23, 1974.

The meetings of the Executive Committee were held prior to the meeting of the Board of Trustees. Inasmuch as the minutes of the Executive Committee meetings have been published in THE JOURNAL and copies of the minutes are in the hands of the Reference Committee, we will not attempt to review the

many transactions handled by this committee.

Unfortunately, Dr. Donald M. Kerr found it necessary to resign as chairman of the Executive Committee in August of this year and the Board of Trustees at its meeting on August 10 filled the vacancy by electing Dr. Eli Goodman of Charlestown to fill the unexpired term of Dr. Kerr. Immediately following the Board meeting, the Executive Committee met again for the purpose of organizing, at which time Dr. Hugh K. Thatcher, Jr., was elected chairman of the committee.

If you have followed the minutes of the Executive Committee in THE JOURNAL, or if you care to review with the Reference Committee, you will find this has been a busy year.

The Journal

Listed below is a comparative report of *The Journal* operations over the past several years and the first six months of 1975, as follows:

The first table shows the number of journal pages for the past six years (includes inserts).

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. No. Pages Per Issue
1969	1041	67	509	33	1550	129
1970	1131	74	403	26	1534	128
1971	970	70	426	30	1396	116
1972	933	69	433	31	1366	113
1973	877	73	321	27	1198	100
1974	870	69	282	31	1176	98

The table below shows the total printing costs of *The Journal*:

Year	Total Printing Costs	No. of Pages (Inserts Excluded)
1970	\$44,520.84	1346
1971	40,542.21	1232
1972	41,789.70	1106
1973	42,642.43	1028
1974	50,895.65	1176
1975 (6 mos.)	29,115.42	571

A comparison of advertising revenues for the first six months of the last four years, with a like figure for 1975, is as follows:

Year (Jan.-June)	Sold by State Medical Journal Adv. Bureau	Sold direct By Journal	Total
1971	\$13,128.30	\$1,821.89	\$14,950.19
1972	17,869.96	1,622.60	19,492.56
1973	10,938.94	2,134.95	13,073.89
1974	10,280.92	3,151.00	13,431.92
1975	9,250.86	3,763.16	13,014.02

Membership Report

Total Members	December 1973	December 1974
ISMA	4,698	4,823
AMA	4,348	4,483
	July 31, 1974	June 30, 1975
ISMA	4,743	4,689
AMA	4,416	4,167

DISTRICT REPORT AS OF JUNE 30, 1975

	+ Gain	- Loss
DISTRICT	ISMA	AMA
1	- 4	- 6
2	-11	- 18
3	+ 2	- 17
4	+10	+ 6
5	- 5	- 17
6	—	- 6
7	-27	-107
8	+ 5	- 17
9	—	- 21
10	- 1	+ 1
11	- 2	- 8
12	- 7	- 19
13	-14	- 20
	-54	-249

DEATHS

December, 1974	58
As of June 30, 1975	31

County-District

Membership Report

	Dec. 31, 1974 ISMA	July 31, 1974 ISMA	June 30, 1975 ISMA	June 30, 1975 AMA
1st DISTRICT				
Gibson	13	13	13	13
Perry	7	7	7	7
Pike	2	2	2	2
Posey	6	6	6	6
Spencer	4	4	4	4
Vanderburgh	280	279	276	256
Warrick	6	6	5	4
TOTAL	318	317	313	292

2nd DISTRICT

Daviess-Martin	20	20	17	14
Greene	16	16	15	11
Knox	44	44	45	42
Owen-Monroe	102	102	93	67
Sullivan	16	15	16	14
TOTAL	198	197	186	148

3rd DISTRICT

Clark	55	55	55	37
Du Bois	25	24	28	25
Floyd	44	44	47	38
Harrison-Crawford	9	9	9	9
Lawrence	42	41	35	23
Orange	6	6	7	6
Scott	8	8	8	8
Washington	8	8	8	7
TOTAL	197	195	197	153

4th DISTRICT

Bartholomew-Brown	70	69	74	64
Dearborn-Ohio	16	15	15	13
Decatur	8	8	11	10
Jackson	*23	*20	18	15
Jefferson-Switzerland	29	27	27	23
Jennings	—	—	7	7
Ripley	11	11	8	7
Total	157	150	160	139
*Jackson-Jennings in 1974				

5th DISTRICT

Clay	15	14	12	11
Parke-Vermillion	14	14	14	13
Putnam	18	18	17	17
Vigo	119	119	117	102
TOTAL	166	165	160	143

6th DISTRICT

Fayette-Franklin	18	18	18	17
Hancock	26	26	25	21
Henry	38	38	36	32
Rush	12	12	12	12
Shelby	22	22	20	16
Wayne-Union	76	74	79	74
TOTAL	192	190	190	172

7th DISTRICT

Hendricks	26	26	27	20
Johnson	35	35	35	24
Marion	1178	1129	1104	1032
Morgan	24	23	20	16
TOTAL	1263	1213	1186	1092

8th DISTRICT				
Delaware-				
Blackford	131	131	135	100
Jay	14	14	13	12
Madison	100	97	99	63
Randolph	18	18	18	12
TOTAL	263	260	265	187

9th DISTRICT				
Benton	7	7	6	4
Boone	18	18	17	14
Clinton	13	13	12	10
Fountain-				
Warren	11	11	11	9
Hamilton	19	18	14	11
Jasper	9	9	8	8
Montgomery	25	25	26	21
Newton	4	4	4	3
Tippecanoe	158	157	166	139
Tipton	12	12	10	9
White	8	8	8	8
TOTAL	284	282	282	236

10th DISTRICT				
Lake	476	475	474	437
Porter	79	77	77	74
TOTAL	555	552	551	511

11th DISTRICT				
Carroll	8	8	9	9
Cass	32	31	27	23
Grant	82	82	81	80
Howard	71	71	73	67
Huntington	18	18	22	17
Miami	13	13	14	14
Wabash	27	27	22	16
TOTAL	251	250	248	226

12th DISTRICT				
Adams	13	13	12	11
Allen	328	327	324	287
De Kalb	19	19	18	15
La Grange	9	9	8	6
Noble	16	16	16	15
Steuben	13	13	12	12
Wells	51	51	51	50
Whitley	13	13	13	13
TOTAL	462	461	454	409

13th DISTRICT				
Elkhart	118	118	109	96
Fulton	7	7	7	6
Kosciusko	18	18	19	13
La Porte	96	94	89	76
Marshall	20	19	21	19
Pulaski	4	4	3	3
St. Joseph	246	243	240	238
Starke	8	8	9	8
TOTAL	517	511	497	459

1st District	318	317	313	292
2nd District	198	197	186	148
3rd District	197	195	197	153
4th District	157	150	160	139
5th District	166	165	160	143

6th District	192	190	190	172
7th District	1263	1213	1186	1092
8th District	263	260	265	187
9th District	284	282	282	236
10th District	555	552	551	511
11th District	251	250	248	226
12th District	462	461	454	409
13th District	517	511	497	459
TOTAL	4823	4743	4,689	4,167

Medical Defense Activities

1. Malpractice Cases. A year ago at the time of this report, August 1974, the following six cases were pending before the committee:

Case 313—Suit filed Sept. 5, 1967. Pending. (Expense to date \$600.00)

Case 314—Suit filed approximately July 6, 1970. Pending.

Case 316—Suit filed July 2, 1970. Pending.

Case 318—Date suit was filed unknown. Closed. (Expense \$2,000.00)

Case 320—Suit filed Feb. 4, 1974. Closed. (Expense \$1,389.50)

Case 321—Suit filed May 30, 1974. Pending.

Since Aug. 1, 1974 and to Aug. 1, 1975, three new cases have been filed, one of which has been closed—Case No. 322. (Expense \$2,000.00)

2. Medical Defense Fund Statement from July 1, 1974, to June 30, 1975:

Bank Balance, July 1, 1974 \$24,756.96

Receipts 5,649.48

Total cash and receipts,

June 30, 1975 \$30,406.44

U. S. Treasury Bonds 25,077.67

Payable to General Fund 950.65

Hugh K. Thatcher, Jr., M.D. *Chairman*
Gilbert M. Wilhelmus, M.D.

Joe Dukes, M.D.

Vincent J. Santare, M.D.

William R. Clark, M.D.

Eli Goodman, M.D.

Donald M. Kerr, M.D., *Chairman,*
resigned

Grievance

HOUSE ACTION: Ordered filed.

The Grievance Committee has not met during the past year, inasmuch as under the actions taken by the House of Delegates it has been the policy of the committee to refer complaints to the physician in hope that he and the patient might resolve their differences and then, if this is not successful, the complaint is referred to the county medical society grievance committee; the state committee now functions only when the county society requests that the state committee take charge. This has been the policy during the past year. The state committee has received five complaints and all have been resolved either between the physician and his patient or the county

medical society involved and the physician and his patient.

RICHARD S. BLOOMER, M.D.,
Chairman

WILLIAM D. PROVINCE, M.D.

EUGENE S. RIFNER, M.D.

KENNETH WILHELMUS, M.D.

HARRY L. CRAIG, M.D.

THOMAS C. TYRRELL, M.D.

LAWRENCE K. MUSSELMAN, M.D.

GENE MOORE, M.D.

Medical-Legal Review

HOUSE ACTION: Ordered filed.

This year the Medical-Legal Review Committee dealt with a minimum number of problems and "sat in the wings" watching with interest the activities of the President and his Ad Hoc Committee working for passage of H.B. 1460. Many of the areas which the committee had considered in the past years involved the dramatic increase of medical liability suits. Our attempt to initiate a binding arbitration system at the Indiana University Medical Center with the help of Chancellor Glenn W. Irwin, Jr., and Dean Steven C. Beering met with failure because of our inability to locate an insurance company willing to cover this group.

At a meeting held January 22, 1975, the problem of unwillingness on the part of some doctors to appear in court to testify for their patients involved in personal injury cases was discussed. This situation was demonstrated to the legal members of our committee by way of a letter of complaint against one of our members, alleging this type of practice. This matter will be considered at the fall meeting of the committee.

There were no court or administrative actions during the past year which needed action relative to Article III, Section 3 of the Interprofessional Code adopted by the Indiana State Medical Association and the Indiana State Bar Association. It is hoped that the proposed change in the Constitution and Bylaws, recommended by the Medical-Legal Review Committee and approved last year by the Board of Trustees, concerning the right of the ISMA to hire an attorney of competence in the medical-legal field to aid physician-members, will be implemented at the House of Delegates in October. This attorney would serve as consultant to a physician's own attorney and hopefully provide added competence and experience.

Our Association has been indeed fortunate to have participated in the enactment of the nation's number one "malpractice legislation," and our committee will wait and watch with eagerness as the ever-increasing number of claims are tested with this new law. There seems little doubt that the frequency of lawsuits against doctors will increase, but

hopefully the panel will function as intended and, contrary to the opinion of the insurance companies, will eliminate the "nuisance" lawsuits which have no factual basis.

Our hats are off to President Gilbert Wilhelmus for his perseverance and leadership and to all those others involved in achieving the passage of H.B. 1460. Time will tell if this legislation will give our members the relief we most certainly require!

JOHN W. BEELER, M.D.

Chairman

JOSEPH G. S. WEBER, M.D.

ROBERT R. KOPECKY, M.D.

GEOFFREY SEGAR

JAMES J. STEWART

WILLIAM HALL

JOHN O'CONNOR

Sports and Medicine

HOUSE ACTION: Ordered filed.

The Committee on Sports and Medicine in 1974-1975 continued to provide liaison between Indiana State Medical Association and especially the Indiana State High School Athletic Association. This committee helped solve many medical problems through this communication at local levels. The committee provided monthly articles in the bulletin of the Indiana State High School Athletic Association pertaining to medicine and athletics for the dissemination of knowledge to high school coaches, teachers and administrators.

The main projects, however, in 1974-75 of our committee are twofold. One was the preparation, organization and presentation of a sports symposium for the annual meeting of the Indiana State Medical Association in French Lick on Oct. 21, 1975. This program will deal with the medical and psychological problems encountered in athletics. The outline of this program and its outstanding speakers from the athletic and medical professions can be found elsewhere in this issue of THE JOURNAL. Dr. Garland Anderson of Fort Wayne is the coordinator of this fine presentation.

The second project of the Committee on Sports and Medicine was to research for a program that would provide greater availability of athletic trainers to the secondary school systems of Indiana. The committee felt that greater paramedical help was needed in the field of athletics. The need for care is on the increase, due to the number and size of programs presently being developed and implemented for women. A program was needed that would provide excellent care for each and every athlete. "Indiana Sports and Medicine Program" was presented to our committee by two members of the National Athletic Training Association—Mr. Pinky Newell of Purdue University and Mr. Dick Hoover, presently in private practice of physical therapy at Glenview,

Ill. They presented a proposal directed toward the planning, organization and implementation of a comprehensive and viable sports-medicine program for the State of Indiana. This program would encompass all of the planned and coordinated activities of professional and voluntary workers whose roles in society are relevant to the concept of sports medicine; i.e., all phases of physical conditioning, athletic training, prevention, treatment and rehabilitation of sports injuries. This would include the involvement of coaches, school administrators, student volunteers, equipment managers, parents and allied health personnel responsible for the administration of medical services and first aid to sports participants.

The state of Indiana is unique in having four state universities offering an approved curriculum in undergraduate athletic training education. Unfortunately, the need in the 500-plus high schools cannot be met by this method of education and placement. The comprehensive program proposed would hopefully satisfy the need for a qualified, educated, certified athletic trainer in each high school at the end of five years. The program would continue to fulfill the need of replacement personnel as normal turnover occurs.

This program will be discussed at the annual meeting on Oct. 21 in French Lick. Presently, means to provide funding for the institution of this or a similar program are being investigated by our committee. In 1975-76, the committee will continue to bring to reality this sort of program of athletic training personnel in Indiana.

Also, another project will be undertaken in 1975-76. The Committee on Sports and Medicine will endeavor to set up a protocol for a practical program for medical safety in elementary, intermediate and senior high schools, and for community sports and recreation programs such as little league, park and recreation departments and similar groups. It will also help to publicize the availability of such a protocol to the public, in particular to physicians who may be involved, and to make this available wherever needed through local medical advisors.

BRAD BOMBA, M.D.

Chairman

ARTHUR L. MOSER, M.D.

ALOIS E. GIBSON, M.D.

WILLIAM B. FERGUSON, M.D.

GARLAND D. ANDERSON, M.D.

LESLIE M. BODNAR, M.D.

ROLLA D. BURGHARD, M.D.

WARD BROWN

SCOTT WILHELMUS

GILBERT M. WILHELMUS, M.D.

JAMES H. BELT, M.D.

PAUL A. WILLIAMS, M.D.

Student Loan

HOUSE ACTION: Ordered filed.

No student loan applications were received this year. Furthermore, no applications have been received since 1970. The federal guaranteed loan program has been discontinued and consequently more students are needing financial help. The Indiana State Medical Association student loan fund, when compared to the American Medical Association-ERF guaranteed loan fund, requires more guarantors or co-signers (one of which must be the spouse); the rate is higher and repaying term is earlier; therefore, the student finds it much easier and beneficial to receive the AMA-ERF loan.

At our meeting the loan committee, following the 1974 House of Delegates' recommendations, first considered transferring the guaranteed fund to AMA-ERF but subsequent discussions with the Indiana National Bank of Indianapolis, our financial participant, has resulted in more realistic changes in our agreement with them. Mr. Malcolm Buck, the assistant vice president of the Indiana National Bank; Mr. Jay Smith, financial assistant to Dr. Steven C. Beering, dean of the Indiana University School of Medicine, and your chairman have been in lengthy discussions and recently have arrived at a tentative agreement on amendments to the present loan agreement which would bring the ISMA student loan fund to almost parallel requirements with that of the AMA-ERF. It is hopeful that these changes will allow for easier and greater participation by the Indiana University medical students of the ISMA student loan fund. Final details of this amendment will be announced to the Board of Trustees for action and will be discussed with the membership at the annual meeting in French Lick.

MALCOLM O. SCAMAHORN, M.D.

Chairman

JOE DUKES, M.D.

PAUL HOLTZMAN, M.D.

JAMES O. RITCHEY, M.D.

HUGH K. THATCHER, JR., M.D.

STEVEN C. BEERING, M.D.

RICHARD FAIRCHILD

Future Planning

HOUSE ACTION: Recommendation Nos. 1, 2, 5, 6, 7 and 8 ordered filed. Recommendation No. 3 referred to Commission on Constitution and Bylaws. Recommendation No. 4 referred to the Board of Trustees

The Future Planning Committee held a meeting May 4 at the headquarters building. Other deliberations were conducted by mail.

Recommendation No. 1: We reiterate the recommendations made to the House of Delegates by our committee in 1973

and again in 1974 that the Future Planning Committee be restructured as a smaller committee with few or no ex officio members, whose time is preempted by their other duties. We suggest that the composition be balanced to include members with experience in Association affairs and others who are beginning their participation in organized medicine, as well as having a student representative of AMSA and a hospital house officer.

Recommendation No. 2: It is our consensus that the Association should formulate explicitly defined objectives at regular intervals with periodic inventories of progress toward achieving these goals. Such a pattern of management by objectives for the Association could be developed by the Future Planning Committee with recommendations and reports to the Board of Trustees and an annual summary to the House of Delegates, similar to the AMA Council on Long-Range Planning.

Recommendation No. 3: A category of *inactive membership* should be devised for those who desire to withdraw from active practice without retiring. Under the new Medical Practice Act, retirement requires the surrender of the license. Such membership should entail nominal dues with retention of eligibility for group benefits, such as insurance, meetings, tours, etc.

Recommendation No. 4: In view of the interdependence of county societies, ISMA, and AMA, a majority of the Committee endorsed a sustained program to encourage all eligible physicians to become and to remain members at county, state and national levels. Means should be sought of facilitating participation by all segments of the profession and of being responsive to them. This might include provision for branch societies in large counties. Physicians who are not self-employed and those who are not in immediate contact with patients should be encouraged to be active and be made aware of the many scientific and educational benefits which ISMA and AMA achieve for the public and the profession, together with the other activities directly beneficial to members. Progress in recruitment of members, particularly recent graduates, should be regularly and innovatively reviewed.

Recommendation No. 5: The Commission on Constitution and Bylaws should review the present geographic composition of all the District Societies regarding current patterns of practice, such as referral of patients, hospital staff orientation, continuing education programs, health planning areas, etc., and recommend appropriate revisions, if indicated.

Recommendation No. 6: A majority of the Committee support seeking ways of encouraging all members of District So-

cieties to participate in the election of trustees and the Blue Shield directors. Mailed ballots are suggested by several members of the Committee.

Recommendation No. 7: The Committee considered, but did not reach consensus, on such topics as (a) development of technics for carrying on bargaining procedures on behalf of members with common interests; (b) establishing a socioeconomic division of the Association to provide data for dealing with other groups, public or private; and (c) further exploration or implementation of computerized data handling and analysis, either for the Association or for members.

Recommendation No. 8: Other items brought before the Committee which received only minimal support were proposals to elect the chairman of the Board of Trustees by the House, to have trustees elected by the delegates from the district, and to have the president-elect ordinarily represent the Association at meetings of other state associations.

The Committee generally agrees that the purview of its actual and potential activities is a desirable function of the Association which a smaller group, meeting regularly, with no "housekeeping chores," should continue to perform, as suggested in Recommendations No. 1 and 2.

PATRICK J. V. CORCORAN, M.D.
Chairman

GEORGE M. HALEY, M.D.
MAURICE E. GLOCK, M.D.
JAMES FITZPATRICK, M.D.
LOWELL H. STEEN, M.D.
PETER R. PETRICH, M.D.
DeWAYNE HULL, M.D.
JAMES T. ANDERSON, M.D.
JAMES H. GOSMAN, M.D.
JOHN M. PARIS, M.D.
TERRY BROWN
GILBERT WILHELMUS, M.D.
VINCENT J. SANTARE, M.D.
DONALD KERR, M.D.
RICHARD INGRAM, M.D.
FRANK B. RAMSEY, M.D.
JOHN W. BEELER, M.D.
WILLIAM R. CAST, M.D.

Convention Arrangements

HOUSE ACTION: Recommendation for the deliberation of the Board of Trustees that, henceforth, the first meeting of the House of Delegates commence on Sunday afternoon, thereafter, Reference Committee meeting be held on Monday morning and section meetings to be held on Monday afternoon. A general scientific program should be made available on Tuesday and the final meeting of the House of Delegates could be held on Tuesday or Wednesday.

Reports of Commissions

Aging

HOUSE ACTION: Ordered filed.

The Commission on Aging met on March 2, April 16 and June 1, 1975, to discuss the Nursing Home situation in Indiana.

Mr. George Heighway of the Indiana State Board of Health was invited to the first meeting to answer questions and give information about what the State Board of Health is doing to control the operation of nursing homes.

Mr. Heighway answered questions about licensing of nursing homes, inspections, profits, relationship between the pharmacist and nursing home and how the Board of Health felt about patients going directly from their families to a nursing home instead of being evaluated first by their physicians.

It was decided that before you can address the nursing home situation attention must first be paid to the population which nursing homes serve—namely, the aged.

The truth is, the aged represent one of the most disadvantaged groups in American society. Approximately one third of all aged Americans are plagued by poverty. Their needs for medical and social services greatly increase at just the time when their ability to pay for such services greatly diminishes, either through retirement or disability. Therefore, the commission feels some external sources are needed by the aged to help at that particular stage in life with the multitude of problems which beset them.

Although there have been some excellent interventions by private external sources such as friends, families, churches, and other charitable groups, a unified, pervasive, effective external source of intervention into these problems for the multitudes of aged in American society has not occurred.

Obviously one external source of intervention might be the government. However, there is still a feeling that each of us should be responsible for his own existence. It is felt that the government is best which governs least.

But there is a growing feeling in our country that stable financing and good care and planning for the needs of the elderly cannot be separated.

The nursing home industry currently receives three quarters of its income from government, and it appears the government will be playing a larger role in nursing home care in the future.

The commission feels we should recognize these trends and do all we can to insure positive programming for the elderly as a result of these trends.

Because of this, the Commission on Aging makes the following recommendations:

1. The funds poured into nursing homes might be better utilized in the provision of day care centers, meal delivery and transportation services to elderly living in their own homes or apartments.

2. Nursing homes should be accredited and licensed by appropriate boards and agencies.

3. The home should be free of accident causing hazards. It should meet state and federal fire safety codes, and there should be obvious evidence of fire safety precautions.

4. Living arrangements should be comfortable and properly equipped. Toilet facilities should accommodate wheelchair patients. The home should be clean, reasonably free of unpleasant odors, and the hallways should be well lighted and reasonably wide.

5. The dining room should be attractive and inviting, and the food nutritionally adequate and tasty. The kitchen should be clean, and there should be some dietary supervision. Normal mealtime should be observed with plenty of time for leisurely eating. Patients who need help in eating should have it available.

6. Rooms for recreational pursuits, private visits, special purpose physical examination rooms, and an isolation bedroom and bathroom should be available.

7. A well established protocol to meet medical emergencies should be operational. Complete and accurate health care records should be kept on every patient, and ready access to a nearby hospital for acute hospitalization should be provided.

9. There should be a sufficient number of registered nurses on duty 24 hours a day and with sufficient L.P.N.s and nurses' aides. Nursing home directors, nurses, L.P.N.s, aides, and ancillary help should be carefully chosen and exposed to in-service training continuously. L.P.N.s should be given the same status as R.N.s in nursing homes because of the shortage of R.N.s.

10. Physicians should be urged to see their patients at regular intervals, and this should be continually emphasized by the State Medical Association to its members.

11. Physicians should be given tax credits for calls on patients in nursing homes.

12. Beds in nursing homes should not be classified, but patients should be.

13. Homes for the aged, nursing homes and county homes must be medical institutions so that at least some older people who enter will be rehabilitated and returned to their communities.

The Commission on Aging realizes that some of these recommendations are already in effect concerning nursing homes, but it is felt that not all of them

are being followed at the present time.

It has been stated that the industry is earning high profits while providing poor patient care. The Moss congressional hearings, television and other news media have exposed considerable swindling of government funds throughout the country. Manipulation of ownership and of mortgages has been brought to light.

Apparently there is little effort put forth to enforce the nursing home regulations as they now exist. Industry lobbyists are influential at the state level in order to insulate some of these homes from proper discipline, and public pressure is lacking to enforce nursing home regulations.

Therefore, the Commission on Aging recommends that it is time for another evaluation of the county homes and nursing homes in Indiana by the proper officials.

As chairman of the commission, I wish to thank the members of the Commission on Aging for their participation. The meetings were productive and I sincerely hope that our endeavors will be of some value in improving the care of the aging in our nursing homes.

NATHAN L. SALON, M.D.

Chairman

JOHN D. WILSON, M.D.

ROBERT O. BETHEA, M.D.

JOSEPH C. DUSARD, M.D.

SHERMAN G. FRANZ, M.D.

PAUL E. HUMPHREY, M.D.

ALBERT M. DONATO, M.D.

D. L. BUCKLES, M.D.

W. MARTIN DICKERSON, M.D.

DANIEL RAMKER, M.D.

LOWELL J. HILLIS, M.D.

PETER CLASSEN, M.D.

A. W. CAVINS, M.D.

T. R. HAYES, M.D.

MISS SALLY THOMAS

Emergency Medical Service

HOUSE ACTION: Ordered filed.

The Commission on Emergency Medical Service met on Sunday, April 13, at ISMA headquarters office. The purpose of the meeting was to review the activities of the Governor's Commission on Emergency Medical Service and to insure the protection of the interests of the physicians of the state in the implementation of these activities and, also, to develop a means of input into the actions and activities of the Governor's Commission. Consequently, Philip K. Martin, the executive director of the Governor's Commission, was invited to the meeting.

Mr. Martin distributed copies of the final emergency medical service rules and regulations which had been submitted to the Governor for implementation, pointing out that the formulation of these rules and regulations had been of priority concern to Dr. Dillon, the chair-

man of the commission, and that most of the efforts of the commission had been directed in preparing this document over the past year. Presently, the commission is involved in other activities such as additional funding for EMS services, the training of emergency medical technicians, and the development of county and regional systems as recommended by the American Medical Association.

The House of Representatives recommended a budget about half what the commission asked for and the Senate bill reduced this figure about 75%. Mr. Martin pointed out it would be impossible to carry out the activities of the commission with this kind of budget. Funding from various sources is available but never has been coordinated, and it is the endeavor of Mr. Martin to accomplish this, plus allocating these monies where they are most needed. A detailed county-by-county survey to determine the kinds of equipment on hand and other details of current emergency medical service programs in operation is to be done.

Current training programs and certification of EMTs throughout the state were discussed. Indiana Vocational Training College of Indiana (Ivy Tech) has been contracted to provide this training in most areas of the state. This was convenient because Ivy Tech was in existence and structured to perform the job; however, it was the consensus of the physicians present at the meeting that they (the physicians) were being left out of this program and were not being consulted or informed of the extent of EMS activities in their own communities. Mr. Martin agreed that in order for the training programs to be effective, physician involvement must be encouraged and that doctors should be doing the instructing of EMTs.

Another area of concern was the establishment of a regional system of coordinating centers by the Governor's Commission. These centers were selected by the commission with the assistance of the Indiana Hospital Association. These centers are to have money channeled to them for EMT training and other aspects of local emergency medical services; and they, in turn, would be responsible for allocating funds in the areas they felt were necessary. Again, it was pointed out that in most cases physicians were not generally aware of these selections and it was felt that the members of the county medical societies should have been consulted.

There were other points discussed, such as the possible realignment of EMS areas because of the National Health Services Act, and patient referral guidelines being established in some areas of the state without the knowledge of Mr. Martin or the Governor's Commission. Mr. Martin stated that there was much activity going on outside the realm of responsibility of the commission. He suggested that the

ISMA Commission on Emergency Medical Service keep a line of communications open with the Governor's Commission through the physician who is on that commission. He stated he would make every effort to work in conjunction with the ISMA Commission on EMS and involve local doctors more in the planning.

As a result, a motion that a letter be written to the Governor's Commission from the ISMA Commission on EMS asking them what they would like for the physicians of the state to be doing regarding the development of emergency medical services planning and programs was moved, seconded and passed. Also, a motion was seconded and passed that the physician appointed to the Governor's Commission be made a member of the ISMA Commission on EMS.

The commission discussed the need for the establishment of a Section on Emergency Medicine within the framework of the ISMA. This would have to be done through a resolution passed by the House of Delegates at the next annual meeting. There will be resolutions submitted to this effect.

The commission felt that ISMA should have official representation at a May meeting of STEP (Society for Total Emergency Programs) in Indianapolis. The Executive Committee of ISMA approved this and Dr. John Suelzer was asked to attend.

Another meeting with Mr. Martin was planned for July 13, 1975.

MARTIN J. O'NEILL, M.D.

Chairman

LARRY W. SIMS, M.D.

ROBERT M. WALKER, M.D.

CHARLES B. CARTY, M.D.

H. S. RILEY, M.D.

DONN R. GOSSOM, M.D.

ARLINGTON M. HUDSON, M.D.

HOWARD WILLIAMS, M.D.

DAVID J. DIETZ, M.D.

G. R. BOUGHER, M.D.

THOMAS R. SCHERSCHEL, M.D.

JEROME H. WAIT, M.D.

DONALD S. CHAMBERLAIN, M.D.

JOHN G. SUELZER, M.D.

MARTIN J. GRABER, M.D.

JAMES D. FINFROCK, M.D.

ROBERT R. TAUBE, M.D.

LARRY COX, M.D.

B. D. WAGONER, M.D.

THOMAS LIFFICK

Governmental Medical Services

HOUSE ACTION: Ordered filed.

Only one meeting of the commission was held at which reports were received from the district and national HEW representatives on PSRO in Indianapolis, HMO, and from the State Welfare Director for Medicaid of Indiana. The results of these reports were published in a previous edition of this year's JOURNAL of the Indiana State Medical Association.

The role of the commission has primarily been that of information gathering. The commission could assume other roles but has not been asked to do so by either the Board of Trustees, the Executive Committee, or the House of Delegates of the ISMA.

The role of the Governmental Medical Services Commission has not been clarified as far as the existing commission is concerned in the upcoming report on reorganization of commission structure to be submitted by the Future Planning Committee of the ISMA.

Included in the final structure of the Commission should be the following:

1. Clear role definition for the new body concerned with governmental medical services.

2. An interrelationship on an ongoing basis with the various governing bodies and with the investigative bodies.

3. A method of developing leadership with expertise in specialized fields of study (social, economic and legislative matters particularly) that will serve all the membership as well as broaden the base of participation of members in ISMA affairs.

LEE H. TRACHTENBERG, M.D.

Chairman

HENRY J. RUSCHE, M.D.

FLORIAN S. DINO, M.D.

FRED D. HOUSTON, M.D.

J. FRANKLIN SWAIM, M.D.

O. LYNN WEBB, M.D.

JEROME E. HOLMAN, JR., M.D.

ROBERT A. MORRIS, M.D.

LOWELL R. STEPHENS, M.D.

JAMES D. REID, M.D.

EVERED E. ROGERS, M.D.

JOHN J. DeFRIES, M.D.

GERALD P. IRWIN, M.D.

L. R. COPELAND, M.D.

MARK BECHTEL

Interprofessional Relations

HOUSE ACTION: Referred to Interprofessional Relations Commission with the recommendation they search for areas of common interest with Indiana State Nurses Association and the Indiana Pharmaceutical Association.

The Commission on Interprofessional Relations met three times during the year.

One of the major topics of discussion was the Joint Practice Commission and the status of its activities. The commission had been organized during 1974 with representatives named from the Indiana State Nurses Association and the ISMA. The group had then drawn up a constitution and bylaws, following which the ISMA and the ISNA had allocated a \$1,000 grant, on a one-time basis, to the commission to assist in beginning its work toward the solution of some of the problem and priority areas which had been agreed upon by the commission.

Following the gathering of data by the staff on the Joint Practice Commission's activity and a report by Dr. Gabriel Rosenberg, who had been chairman of the ISMA Commission on Interprofessional Relations and vice chairman of the Joint Practice Commission, it was learned that little had been undertaken by the Joint Practice Commission; and the funds allocated had never been utilized.

The activity of the Joint Practice Commission had been somewhat thwarted by the unreported nurse chairman's withdrawal from membership in the Indiana State Nurses Association. Cooperation between the ISNA and ISMA was further complicated by the apparent unwillingness of the ISNA to work co-operatively with the ISMA in legislative support, especially in the effort expended toward solution of the professional liability crises in Indiana. President Wilhelmus had so advised the Nurses Association of this matter.

At the time of this report the ISMA had cancelled payment on the grant of \$1,000 to the Joint Practice Commission.

Because of the critical nature of the professional liability crises in Indiana, the commission also discussed the need for a continuing communication between the legal and medical professions in Indiana. This was additionally emphasized by the commission's concern toward obvious leaks in information from some hospitals to plaintiff attorneys concerning patients who might have potential grounds for suits against doctors.

Following considerable discussion of both matters in which the legal counsel of the Indiana Hospital Association met with the commission to discuss both areas of concern, the commission recommended to the Board of Trustees of the ISMA that top officers of the Indiana State Bar Association and the ISMA meet periodically to discuss common problems regarding medical and legal interests.

The commission also discussed a proposal of the Indiana State Nurses Association concerning the return of the student nurse to the operating room for experience. The Indiana State Nurses Association had pointed out that they had circulated a questionnaire to 135 hospital directors of nursing and to 30 directors of schools of nursing to gather data on the need for reaching a goal for more education in the operating room. The returns on the questionnaire indicated overwhelmingly that the hospitals and schools favored this objective.

The type of training for student nurses was favorably discussed by the commission, which recommends that such training be encouraged by the membership of the Indiana State Medical Association.

The commission also during the course of its year heard a detailed report on the current status of the physician assistant program in Indiana and throughout the nation from Dr. Raymond Murray, di-

rector of the Regenstrief Institute and the Department of Community Health Services at Indiana University School of Medicine.

Some of the points made by Dr. Murray included the following:

1. Twelve P.A.s were graduated last year from the I.U. course at Fort Wayne and eighteen more will be graduated in August 1975.

2. There have been 56 family nurse-practitioners trained in the past three months, with 22 additional nurse practitioners to begin training in July 1975.

3. There are 50 approved P.A. programs in the U.S. today. Such approval is granted by the American Medical Association, the American Academy of Family Practice and one or two other national medical bodies.

4. Dr. Murray expressed the thought that the Board of Licensure should have control over P.A.s concerning definitives for what they can do and requirements for certification or registration.

5. The P.A. can only carry out those activities in a hospital which are predetermined by the hospital staff. In some hospitals they can write orders; in others they are not permitted in the hospital.

6. Concerning professional liability problems, there is no record of a doctor in Indiana, who is utilizing a P.A., having been sued.

Additionally, during the course of the year the commission made efforts on two occasions, unsuccessfully, to meet with the Indiana Pharmaceutical Association representative to discuss common problems.

MARVIN E. PRIDDY, M.D.

Chairman

ALBERT S. RITZ, M.D.

JACK L. SHANKLIN, M.D.

WILLIAM E. SCULLY, M.D.

MARK E. SMITH, M.D.

CLYDE G. CULBERTSON, M.D.

AMBROSE PRICE, M.D.

JACOB SCHEERES, M.D.

MITCHELL E. GOLDENBURG, M.D.

J. DEAN GIFFORD, M.D.

WILLIAM J. STOGDILL, M.D.

RICHARD W. HOLDEMAN, M.D.

RICHARD L. VEACH, M.D.

GABRIEL J. ROSENBERG, M.D.

Legislation

HOUSE ACTION: Ordered filed. Doctor Scamahorn gave a supplemental report in which he thanked the Indiana Medical Federation for its financial help and manpower in passage of H.B. 1460.

The first session of the 99th General Assembly of Indiana was one which had medical legislation as its major action. The Ad Hoc Committee on Medical Liability Insurance, chaired by President Gilbert M. Wilhelmus, M.D.; William Cast, M.D., and Paul Muller, M.D., did a magnificent job in getting Indiana's

medical liability landmark bill through both Houses and signed. The Auxiliary and our entire membership need to be recognized for their outstanding help. A special report will be made by this committee to the House of Delegates.

The other piece of medical legislation presented to the legislature was the Medical Practice Act. It was a revised version of the Act approved by the 1974 House of Delegates. Specifically it (1) did *not* contain anything regarding the Physician Assistant, (2) did add *suspension and probation* to the powers of the Board of Medical Licensure, and (3) did make it *easier for the foreign medical graduate to qualify for state licensure examination* because it did require the foreign medical graduate to either have two years of approved hospital training prior to his examination or, if no approved hospital training, to remain in Indiana on a preceptorship for two years—but not to do both as was required in the previous bill. (It is suggested that the 1975-76 Commission study and support a Physician Assistant Act which is being prepared for introduction to the legislature.)

The Medical Practice Act passed without great opposition; however, in the last days of the session, Senate Bill 111, which had been opposed by the Indiana State Medical Association, did, by joint committee recommendation, receive passage as an amendment to the Medical Practice Act. This amendment was subsequently vetoed by Governor Bowen. S.B. 111 would allow any foreign medical graduate applicant who held an ECFMG certificate to be given full licensure in Indiana without examination and then a two-year preceptorship would be required within the state. Southern Indiana, Inc. and the bill's sponsor have called for an override of Governor Bowen's veto. Your commission is sure that such an override will be attempted. ISMA is opposed to this amendment to the Medical Practice Act and will support Governor Bowen's veto.

More than 100 bills were studied by your Commission on Legislation as relating directly to physicians and to the health care of Indiana. There were studies and recommendations as to whether any of these bills would be (1) supported, (2) opposed or (3) taken for information only. The subjects were from such areas as restaurant laws, contraceptive advice, higher education, acupuncture, and through the gamut of all kinds of things such as insurance in general, workman's compensation, and vehicle operator's license. A total of six meetings was held during the session, and the attendance was very excellent from all trustee areas. The Auxiliary was always represented and their help was deeply appreciated.

It was a successful session for medicine, but the Commission feels that in the future all proposed medical legislation should be handled by one committee,

since communications and flaking side issues can become confusing for the legislators and the ISMA legislative staff as well. This breakdown in communications and in the side issues of the various proposed acts often causes problems. The Commission wishes to recognize the ISMA staff for their excellent support and leg work.

Outstanding this session was the attendance at the Commission meetings of the three physician legislators—Floyd Coleman, M.D., of Waterloo, E. Henry Lamkin, Jr., M.D., of Indianapolis, and Anthony Pizzo, M.D., Bloomington. Their opinions and discussions were most helpful not only to the Commission but to the Ad Hoc Committee and they were most invaluable in certain key decisions.

The Commission will continue to hold interim meetings if necessary before the next session to prepare any new legislation or study new proposed legislation and, if necessary, an amended report will be filed at the annual meeting in French Lick.

MALCOLM O. SCAMAHORN, M.D.

Chairman

JOHN A. KNOTE, M.D.

ROBERT M. SWEENEY, M.D.

THOMAS HARMON, M.D.

IVAN A. CLARK, M.D.

JOE BLACK, M.D.

WILLIAM BANNON, M.D.

JOHN A. DAVIS, M.D.

JOHN PANTZER, M.D.

RICHARD L. REEDY, M.D.

A. P. BONAVENTURA, M.D.

RICHARD L. GLENDENING, M.D.

JERRY L. STUCKY, M.D.

DON WOOD, M.D.

JAMES KIRTLEY, M.D.

FRED SMITH, M.D.

JOSEPH McPIKE, M.D.

LEONARD W. NEAL, M.D.

JOHN B. WHITE, JR., M.D.

MARY FORSTER

MRS. JACK WALKER

MRS. WILLIAM RAGAN

Medical Economics and Insurance

HOUSE ACTION: Ordered filed.

It is with a feeling of regret that we must report the untimely death of Dr. K. O. Neumann, who had been chairman of the Commission for so many years. He took with him a great deal of the work and planning that was carried on up to that time.

A meeting was held by the Commission on May 28th at the headquarters building, at which time we heard from Aetna Life and Casualty, which is not interested in writing any malpractice insurance at all, and Hartford Insurance Company, which is not planning on increasing their coverage. St. Paul Fire and Marine Insurance Company will only write "claims-made" policies as of July

1st this year. They have enrolled approximately 800 doctors in the state. The Travelers Insurance and U.S.F.&G. were not present. The Medical Protective Company is not seeking any new business with the exception of the newly graduated M.D.'s. We had reports from CNA who showed an interest in working up a statewide program which would cover all the physicians in Indiana under one policy.

As of the date of this report, there have been no hard and fast rules established either by our society or the state Insurance Commissioner as to the exact nature of our insurance availability, or how much the rates will be. Rest assured that your Commission will keep abreast of the developments of the various companies, i.e., any change in rates that might occur or rates being lowered due to our new law that has taken effect. Frankly, it seems very possible that it will be at least 2 years before there is any reduction in malpractice insurance. Our suggestion at this time is to keep the insurance that you now have in force. If you are unable to obtain insurance, you will have to become a member of the "pool" which is explained in the law.

The Commission goes on record that we recommend the "occurrence type" policy and not any "claims-made" policies.

ROBERT O. ZINK, M.D.

Chairman

Leo R. NONTÉ, M.D.

ROGER F. ROBISON, M.D.

FRANCIS H. GOOTEE, M.D.

JACK G. WEINBAUM, M.D.

ROBERT P. INLOW, M.D.

FREDERICK EVANS, M.D.

LARRY G. COLE, M.D.

HARRY TO STOUT, M.D.

R. JAMES BILLS, M.D.

WILLIAM R. CAST, M.D.

ROBERT D. CHANEY, M.D.

ROBERT C. STONE, M.D.

WALLACE S. TIRMAN, M.D.

JACK W. HANNAH, M.D.

JOEL W. SALON, M.D.

R. ADRIAN LANNING, M.D.

PAUL M. INLOW, M.D.

THOMAS J. CONWAY, M.D.

STEVE RATCLIFFE

Medical Education and Licensure

HOUSE ACTION: Ordered filed.

The Commission and its Accreditation Committee each held three meetings during the past year. The major work of the Commission included:

(1) Review of Site Team Survey and accreditation materials concerning Indiana hospitals and specialty societies.

(2) Approval of the following hospitals and societies:

Huntington Hospitals, Huntington
St. Mary Mercy Medical Center, Gary
Bloomington Hospital, Bloomington

Lafayette Medical Foundation,
Lafayette

Methodist Hospital of Indiana,
Indianapolis

Gary Methodist Hospital, Gary

Caylor-Nickel Clinic, Bluffton

Indiana Philippine Medical Society

Indiana Society for Internal Medicine

Indiana Psychiatric Society

St. Catherine Hospital of East Chicago

St. Joseph Memorial Hospital,

Kokomo

(3) The development and display of a Continuing Medical Education booth at the 1974 State Convention to promote the Physician Recognition Award and the Accreditation Program.

(4) Review and approval for Category I Accreditation of the scientific portion of the 1975 ISMA Convention Program.

(5) Provision of a validated record of meeting attendance for annual convention participants.

(6) Provision of a monthly printout of Indiana physicians receiving the Physician Recognition Award as well as the provision of a gold ISMA membership card and the addition of the ISMA seal to the PRA certificate. In the first five months of 1975, 125 Indiana physicians qualified for the PRA.

(7) Members of the Commission actively participated in the legislative efforts concerning the Medical Practice Act and the Patient Compensation Act.

(8) The Commission again participated in the planning and implementation of the Annual Student-Physician-Faculty Retreat which was held in March 1975 at the Brown County Inn in Nashville. The complete report of this Retreat will be published in a future issue of the ISMA JOURNAL.

(9) The following Commission members deserve special recognition for acting as liaison officers with other organizations during the year:

Dr. Ellis, Dr. Stogsdill, Mr. Roscoe—
CONVENTION ARRANGEMENTS

Mr. William Beeson—MEDICAL
STUDENT AFFAIRS

Dr. Dan Lowe—HOUSESTAFF AFFAIRS

Dr. Cullison, Dr. Wagner—GRADUATE MEDICAL EDUCATION AND THE ASSOCIATION OF INDIANA DIRECTORS OF MEDICAL EDUCATION

Dr. Franklin Bryan—BOARD OF TRUSTEES AND LEGISLATIVE LIAISON

Dr. Ross Egger—INDIANA ACADEMY OF FAMILY PHYSICIANS AND CME COMMITTEE OF THE COUNCIL ON MEDICAL EDUCATION

Dr. Merritt Alcorn—INDIANA MEDICAL LICENSING BOARD

STEVEN C. BEERING, M.D.

Chairman

GILBERT M. WILHELMUS, M.D.

JEAN ARTHUR CREEK, M.D.

RICHARD RIEHL, M.D.

STANLEY FRODERMAN, M.D.

DAVIS W. ELLIS, M.D.

DONALD M. SCHLEGEL, M.D.

HAROLD E. NELSON, M.D.

RICHARD R. HUGHES, M.D.

NICHOLAS L. POLITE, M.D.

SHOKRI RADPOUR, M.D.

RONALD H. SCHEERINGA, M.D.

THOMAS A. ELLIOTT, M.D.

LESLIE BAKER, M.D.

LINDLEY WAGNER, M.D.

JOHN L. CULLISON, M.D.

ROSS L. EGGER, M.D.

MERRITT O. ALCORN, M.D.

WILBERT McINTOSH, M.D.

JOHN ROSCOE

WILLIS STOGSDILL, M.D.

EUGENE M. GILLUM, M.D.

WILLIAM BEESON

DANIEL K. LOWE, M.D.

FRANKLIN A. BRYAN, M.D.

Supplemental Report of the Commission on Medical Education and Licensure

The list of approved hospitals and societies was incomplete as published in the September Journal. A complete list follows:

Huntington Hospital, Huntington

St. Mary Mercy Medical Center, Gary

Bloomington Hospital, Bloomington

Lafayette Medical Education Founda-

tion, Inc., Lafayette

Methodist Hospital of Indiana, Indianapolis

Gary Methodist Hospital, Gary

Caylor-Nickel Clinic, Bluffton

St. Catherine Hospital of East Chicago

St. Joseph Memorial Hospital, Kokomo

Ball Memorial Hospital, Muncie

Union Hospital, Terre Haute

Community Hospital, Indianapolis

Indiana Philippine Medical Society

Indiana Society for Internal Medicine

Indiana Psychiatric Society

Public Health

HOUSE ACTION: Ordered filed. Special note should be made the Commission has learned that the Superintendent of Public Instruction cannot require immunization as a prerequisite for school entrance.

The Commission met twice during the period October 1974-June 1975.

At the first meeting in December 1974, Dr. James Johnson was elected vice-chairman and Dr. Robert Seibel was elected secretary. The annual report of the Commission was reviewed and the minutes of the last previous meeting were abstracted for discussion.

It was recommended that a position paper from the Citizens League for Nursing, previously referred to the Board of Trustees, be reevaluated and recommended for conference with the League, if the Board of Trustees concurred. The

paper was endorsed in principle but important modifications were needed for unequivocal support from the Association.

The Commission heard an in-depth presentation from Dr. James F. Bowes, Dow Chemical Company, in support of a compulsory vaccination statute for Indiana.

The Commission recommended that the authority of the Superintendent of Public Instruction be investigated to determine his ability to require, by regulation, immunization as a prerequisite to school entrance.

Dr. Robert Yoho, Assistant State Health Commissioner, discussed the matter of regionalization of local health departments. Dr. Yoho pointed out that some structure, by whatever name, is needed to strengthen and thus permit local health departments to be more effective. Dr. Yoho predicted that the upcoming Legislature would discuss this matter and refer it to a study committee.

The Commission restated its support of this concept and recommended that the ISMA Legislative Commission support this position.

Mature consideration was given to a proposal from the Indiana Lung Association (formerly, Indiana Tuberculosis Ass'n.) for repeal of the law requiring tuberculosis tests for children entering school.

The Commission opposed repeal of this law pending demonstration of the value of such repeal.

There was extensive discussion of a proposal from the Department of Mental Health regarding repeal of the law concerning public intoxication. The major impetus for such repeal lay in the concept that upon arrest for public intoxication the person so arrested could be placed in a treatment facility. The commission noted that the present law has such a provision and that there was inadequate basis for repeal cited in the presentation.

In view of the tenuous basis for repeal, the Commission did not find it advisable to approve or disapprove the proposal.

The Commission reviewed a request from the Indiana University Developmental Training Center for a list of medical personnel interested in retarded and/or disturbed children.

There being no such information available in the Association, the Center was to be so informed.

Subsequently, the Commission learned that the Superintendent of Public Instruction could not require immunization as a prerequisite for school entrance.

The Commission also approved the program of the Immunization Action Month Committee as an ongoing effort to increase the immunization level of children in Indiana. This was a restatement of the previous year's recommendation.

Mr. Robert Sullivan, ISMA staff, pre-

sented a public information program for immunization education. It was noted to be both well-conceived and oriented. The Commission recommended that the Board of Trustees adopt the proposed plan of action.

The chairman expresses gratitude to the members of the Commission for their continued support and participation and to Mr. Bush for his aid as a staff representative.

A. C. OFFUTT, M.D.

Chairman

A. W. BROCKMOLE, M.D.

EDGAR CANTWELL, M.D.

R. M. SEIBEL, M.D.

JAMES JOHNSON, M.D.

F. B. WARRICK, M.D.

B. L. STEGER, M.D.

K. W. KOSS, M.D.

PATRICIA GALLAGHER, STUDENT

B. A. WORK, M.D.

HERSCHEL BORNSTEIN, M.D.

W. K. NEWCOMB, M.D.

J. J. HARRIS, M.D.

R. E. NELSON, M.D.

HUBERT GOODMAN, M.D.

N. L. NEIFERT, M.D.

E. A. CAMPAGNA, M.D.

RICHARD G. HUBER, M.D.

Public Information

HOUSE ACTION: Ordered filed. Recommendation referred to the Board of Trustees that the unused portion of the funds allocated to the Speakers Bureau for public information be returned to the general fund and that the Executive Committee in its proposed budget allocate sufficient funds to be used for the appropriate commission for public speaking and information.

The Commission on Public Information met in January, February, April and June 1975.

The commission's first matter of business was to get final approval of the information contained in the insurance pamphlet, "You and Health Insurance," drafted by Dr. Ahler, a member of the commission. This was accomplished and the pamphlet was printed by the Franklin Printing Company at a cost of \$2,000 for 100,000 copies. It was decided by the commission that each doctor would receive one copy free with additional copies available at three cents per copy. The pamphlet was produced to provide the patient with some basic guidelines regarding health insurance so they would be better equipped to make sound judgments regarding the financing of their future health care needs.

Tel-Med, a toll-free telephone medical information service of ISMA which has been widely acclaimed as an excellent piece of public relations, is now available to the blind. The commission, acting upon a request from St. John's Hickey Memorial Hospital, contacted Mrs. Harriett Whitson who agreed to transcribe

the Tel-Med pamphlet into braille. After this was completed, the Indiana School for the Blind printed it and it was distributed by Headquarters Staff to the proper blind outlets in the state.

The Speakers Bureau is now operational and functioning quite well. The speakers were briefed on the medical liability problem and incorporated the information into their presentations. The speakers reported they received many questions concerning the problem during their speaking engagements. One speaker, Stan Evans, moved to Washington, D.C., which cut the speakers available to three. However, Joel Marsh was interviewed at the June meeting as a possible speaker. More speakers are needed if the program is to be a continued success.

Another public relations program the commission is trying to implement is one which will provide 30- and 60-second spot announcements to radio and television stations around the state about medical information. At the present time the commission is talking with Mr. Tim Spencer, proprietor of Free Lance Associates and a member of the Speakers Bureau, about getting the program off the ground. One possibility is his Bicentennial program called "The Quest for Freedom," which is about the Revolutionary War period. The program would cost \$17,000 for one year and would allow the Association to insert 60-second spot announcements prior to the information about the Revolutionary War being heard. This program would be sold to 20 communities around the state and would be played for 13 weeks in each area. The Board of Trustees of the Indiana State Medical Association has not yet given its final approval for this program. This commission intends this to be an ongoing program to supplement the Speakers Bureau.

The Commission also made its selections for the Journalism Awards and for the Physician Community Award. These awards will be presented at the Indiana State Medical Association's annual meeting in October.

The President of the Association was requested by the commission to write a letter of thanks to all media in Indiana and some TV stations in Chicago for their objectivity in reporting the medical liability crisis in Indiana.

Another suggestion forwarded to the Board of Trustees by the commission was that ISMA conduct an accountability session with the general public prior to their annual convention. It was felt this would be a good way to find out what the layperson is thinking about medicine and by letting them know physicians care is good public relations.

A pamphlet on High Blood Pressure which is proposed by Blue Cross and Blue Shield of Indiana, was approved by the commission and is now awaiting ap-

proval of the Board of Trustees. If it is approved, the front cover will state, "A Community Service Program of Blue Cross and Blue Shield of Indiana and the Indiana State Medical Association."

Finally, the commission unanimously voted to send a letter of commendation to Malcolm O. Scamahorn, M.D., for the excellent job he did on the Audio Tape "INFO" Program.

DAVID G. CRANE, M.D.
Chairman

CHARLES HACHMEISTER, M.D.
THOMAS O. MIDDLETON, M.D.
LOUIS H. BLESSINGER, M.D.
ROBERT P. ACHER, M.D.
MILTON HERZBERG, M.D.
HARRY T. HENSLEY, M.D.
PAUL BURNS, M.D.
KENNETH J. AHLER, M.D.
JOEL HULL, M.D.
EUGENE T. KARNAFEL, M.D.
JOHN C. HARVEY, M.D.
JOHN LUCE, M.D.
WILLIAM B. CHALLMAN, M.D.
ROBERT W. HARGER, M.D.
HARRY G. BECKER, M.D.
JAMES A. TATE, M.D.
LOUIE O. DAYSON, M.D.
ROSS L. EGGER, M.D.
FRED DAHLING, M.D.

Special Activities

HOUSE ACTION: Taken for information.

Commission meetings have not been held this past year because the Commission on Special Activities has not been charged with any particular tasks or responsibilities by the President.

HANUS J. GROSZ, M.D.
Chairman

RICHARD B. HOVDA, M.D.
ROBERT E. CHATTIN, M.D.
JOHN P. SALB, M.D.
C. DAVID RYAN, M.D.
HUGH E. GLOCK, M.D.
JOSE S. CABIGAS, M.D.
DONALD HUNSBERGER, M.D.
FAE H. SPURLOCK, M.D.
DAVID E. ROSS, M.D.
GEORGE WAGONER, M.D.
NORMAN BEAVER, M.D.
THOMAS J. QUILTY, M.D.
PETER E. GUTIERREZ, M.D.
ROBERT P. ACHER, M.D.
RICHARD D. HAWKINS, M.D.
DWIGHT W. SCHUSTER, M.D.
CRAIG MOORMAN

Voluntary Health Agencies

HOUSE ACTION: Adopted with the recommendation that the valuable monitoring service be continued.

The Commission on Voluntary Health Agencies met twice during the year to complete its business.

After review of the usual comprehensive reports which are required by the Commission from the state's voluntary health agencies who desire approval, the following agencies were placed on the Association's approved list for 1975-76:

American Cancer Society, Indiana Division, Inc.
American Heart Association, Indiana Affiliate, Inc.
American Lung Association of Indiana
Arthritis Foundation, Indiana Chapter
Hemophilia of Indiana, Inc.
Indiana Committee to Combat Huntington's Disease, Inc.
Indiana Easter Seal Society for Crippled Children and Adults, Inc.
Indiana Society for the Prevention of Blindness, Inc.
Kidney Foundation of Indiana, Inc.
Mental Health Association in Indiana
The National Foundation, March of Dimes
National Multiple Sclerosis Society, Indiana Chapter
Tri-State Epilepsy Association, Inc.

Once the organization are approved, their names are circulated via a placard to hospitals and individual physicians. The agencies also distribute thousands for the benefit of the contributing public.

As the program has grown over the past 12 years, the agencies seeking approval have increased and recognize the approval program as a vital part of their public acceptance as ethical organizations operating on a high level of fund-raising, research and community service programming.

Very active again this year were representatives of the Woman's Auxiliary, who assisted the commission in evaluating reports of agencies by meeting with committees and boards of agencies and in many other ways.

Also active again at Commission meetings were three representatives, elected by the agency executives to represent them.

On April 6, 1975 the commission held its annual session with executives and

other officials of the voluntary health agencies. This meeting has become a part of the format of the Commission's activities during each year. The meeting consists of an informal exchange of information between the Commission's activities and the current activities of the various agencies. Recommendations are made each year by all to aid in the continuance of good relations.

One of the joint projects now underway by the Commission and the agencies is the development of an informative booklet which would contain listings of the officials of the approved agencies, their services offered and programs conducted. The format is to be brief and concise with distribution to physicians, industries and other appropriate organizations throughout Indiana.

As chairman of the Commission I wish to express my sincere appreciation for the efforts of the Commission members, the Commission representatives of the Woman's Auxiliary, and for the fine spirit of cooperation of Indiana's voluntary health agencies.

LOWELL W. PAINTER, M.D.
Chairman

E. De VERRE GOURIEUX, M.D.
CHARLES W. McCLARY, M.D.
DONALD M. KERR, M.D.
ELTON HEATON, M.D.
JOHN ELLETT, JR., M.D.
DONN R. HUNTER, M.D.
CHARLES RUSHMORE, M.D.
LAWRENCE E. ALLEN, M.D.
ROBERT W. VERMILYA, M.D.
WALFRED A. NELSON, M.D.
WENDELL W. AYRES, M.D.
RUSSELL GRAF, M.D.
HARRY STIMSON, M.D.
ALVIN T. STONE, M.D.
ROBERT W. BRIGGS, M.D.
JOSEPH W. YOUNG, M.D.
ANTHONY COSSELL
HAROLD R. WARD
WILLIAM C. WILSON
MRS. RALPH B. MILBURN
MRS. JAMES GUTHRIE
MRS. HERBERT SEDAM
MRS. RONALD KLEOPFER
MRS. RICHARD McILROY
MRS. PHILIP L. SMITH
MRS. HAROLD R. WIREY
MRS. J. J. LIND
MRS. A. WAYNE RATCLIFFE
MRS. JACK WALKER

Constitution and Bylaws

HOUSE ACTION: The amended revised Constitution was introduced and approved but will lay over until the 1976 meeting before final action is taken.

Amended Constitution

ARTICLE I.—NAME OF THE ASSOCIATION

The name and title of this organization shall be the Indiana State Medical Association.

ARTICLE II.—PURPOSE OF THE ASSOCIATION

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the state of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education; to promote friendly intercourse among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care, and public health, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

ARTICLE III.—COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Association.

ARTICLE IV.—COMPOSITION OF THE ASSOCIATION

Section 1. This Association shall consist of Active Members, Associate Members, Interns and Residents, Senior Members, Honorary Members, Disabled Members, Distinguished Members, Military Service Members, Public Health Service Members, Retired Members and members of the Indiana Chapter of the American Medical Student Association.

Section 2. Active Members. The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant active membership therein on a basis that does not include membership in the district medical society and in the Indiana State Medical Association.

Section 3. Interns and Residents. Interns and Residents who hold membership in the Indiana State Medical Association shall have all the rights and privileges of this Association.

Section 4. Student Members. Students who hold active membership in the Indiana Chapter of the American Medical Student Association. *[shall have all the rights and privileges of this Association and shall elect one delegate and one alternate delegate. The delegate, or in his absence, the alternate delegate, shall have all the rights and privileges of the House of Delegates with the power to vote.]*

Section 5. Associate Members. Members of the Indiana State Dental Association in good standing are, by virtue of their membership therein, made associate members of the Indiana State Medical Association.

Section 6. Senior Members. Senior members shall be

eligible for Senior Membership on January 1 following their 70th birthday and they shall be physicians of the State of Indiana and who have held membership in the Indiana State Medical Association for 20 years or more; or who have held membership in the Indiana State Medical Association or in some one or more other like state organization which is a component state organization of the American Medical Association, for a combined total of 20 years or more, and who, upon their application, have been certified to the Executive Secretary as eligible for such membership by the county societies of which they are members. It shall be the duty of the county medical society to verify, through the office or offices of any other state organization or organizations, the fact of membership therein when such membership is claimed as part compliance with the eligibility requirement of 20 years of membership.

Section 7. Honorary Members. Honorary members shall consist of teachers, scientists and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates, desire to confer such membership as a special honor.

Section 8. Distinguished Members. Active members who have fulfilled the American Medical Association's Physician Recognition Award requirements of 150 hours for three years of continuing medical education as a minimum shall be designated as Distinguished Members.

Section 9. Disabled Members. Disabled Members shall consist of physicians of the State of Indiana who are certified by a member physician to be permanently disabled and no longer able to practice medicine and who continue to reside in the State of Indiana. Proof of permanent disability shall be by notification to the secretary of the Association by the secretary of the county medical society in which such permanently disabled physician holds membership.

Section 10. Military Service Members and Public Health Service Members. Any physician who is actively engaged in the military service or public health service shall be eligible for membership in the Association with payment of reduced dues; they shall receive THE JOURNAL.

Section 11. Rights and Privileges of Members. Active members, intern and resident members, senior members, military service members, public health service members, disabled members, honorary members, student members and retired members shall have the same rights and privileges except as follows:

(a) Senior members shall not be required to pay membership dues in the State Association.

(b) If senior members desire to receive THE JOURNAL of the State Association, they shall pay the regular subscription price therefor.

(c) Senior members who desire the benefit of medical defense as provided by the Bylaws of this Association shall pay the amount stipulated in Section 1, Chapter XXXIV of the Bylaws for this coverage.

(d) Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold elective office. They shall not be required to pay membership dues in the State Association. Such honor may be conferred by the vote of the House of Delegates.

(e) All such disabled members, as defined in Chapter IV, Section 9, shall receive membership cards and THE JOURNAL of the Association without charge.

(f) Student memberships may be represented in the House of Delegates with all the rights and privileges and the power to vote. They shall be entitled to send one delegate or one alternate who are members of the Indiana Chapter of the American Medical Student Association. *Student delegate and alternate* are to receive THE JOURNAL of the State Association.

(g) Retired members who have chosen voluntary retirement from the practice of medicine before the age of 70 shall only be required to pay membership dues in the amount of one half of the full membership dues applicable at the time of retirement.

ARTICLE V.—HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative and policy-making body of the Association and shall consist of (1) Delegates, or their designated alternates, elected by the component county societies; (2) the Trustees, or their designated alternates, and (3) the ex-presidents of the Indiana State Medical Association. The delegate or their designated alternate delegate elected by their respective section shall also be a member but without power to vote. The following shall be *ex officio* members: The President, the President-Elect, the Executive Secretary, the Treasurer and Assistant Treasurer of this Association, the Speaker, the Vice Speaker and the delegates to the American Medical Association, all without power to vote, *except the Speaker and Vice-Speaker who shall vote as set forth in Section 2 hereafter.*

Section 2. *The Speaker shall preside at all meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.*

He may address the House of Delegates at the opening meeting of all conventions, limiting his address to matters of conduct and procedure in the House. He is entitled to vote when the vote is by ballot. In all other cases, he shall have the right to vote only in case of a tie.

He shall be elected annually from the membership of the House. *Ex officio*, the Speaker shall be a member of all Commissions and Committees and the Board of Trustees of this Association without the power to vote. Training in parliamentary procedure shall be mandatory for the Speaker and shall be provided at the expense of the Association.

Section 3. The Vice Speaker of the House of Delegates shall officiate at meetings in the absence of the Speaker or at the request of the Speaker. The Vice Speaker shall be elected annually from the membership of the House. *Ex officio*, he shall be a member of all Commissions and Committees and the Board of Trustees of this Association without the power to vote. Training in parliamentary procedure shall be mandatory for the Vice Speaker and shall be provided at the expense of the Association. *In the case of death, resignation or removal of the Speaker, the Vice Speaker shall officiate during the unexpired term.*

Section 4. All sessions of the House of Delegates shall be open to all members in good standing of this Association for observation.

ARTICLE VI.—BOARD OF TRUSTEES

The Board of Trustees shall consist of (1) the Trustees with power to vote and their duly elected alternates,

each of the latter without power to vote *except when the Trustee is not in attendance*; and (2) *ex officio*, the President, President-Elect, Treasurer, Immediate Past President with power to vote, Assistant Treasurer without power to vote *except in case the Treasurer is not in attendance*, and the Speaker and Vice-Speaker without power to vote.

Section 1. *Election—Trustee and Alternate. The Trustees shall be elected by the respective district societies. If any district fails to meet and elect its Trustee(s) or Alternate Trustee(s) by the time of the expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election.*

(a) The term of the elected Trustees shall be for three years and approximately one third of the number shall be elected annually. No Trustee shall be eligible to serve longer than two consecutive three-year terms.

(b) Each Trustee district shall elect an Alternate Trustee whose term of office shall be for three years. The Alternate Trustee shall be elected in a year during which his Trustee is not elected.

(c) If any elected Trustee fails, without reason acceptable to the Board, in any one calendar year to attend a majority of the meetings of the Board, he shall thereby cease to be a Trustee, and the Executive Secretary shall thereupon take action in accordance with Section (d) of this Article.

(d) In the event of a vacancy occurring from any cause, except expiration of the term of office, in the office of any District Trustee, the duly elected Alternate Trustee from the same district shall succeed to the office of the Trustee in that District for the unexpired term of said Trustee. In the event vacancies occur in any Trustee District in the offices of both Trustee and Alternate Trustee, the vacancies shall be filled by an election by the members of the Association within the Trustee District in which the vacancies occur. A call for such elections shall be issued by the Executive Secretary of the State Association following a conference(s) with the officers of the District organization. The call shall state the time and place of holding the election and shall be sent registered mail to the County Secretary as filed in the State Secretary's Office of each component society within the District. Such call shall be mailed within ten days after the State Secretary has learned of the vacancies. The election may be held at a special or regular meeting at which business other than the election may be transacted. Such election shall be held within fifteen days after the Secretary of the State Association shall have mailed such call.

Section 2. *Composition. The Board of Trustees shall consist of 22 members, 14 elected as provided in Article VI, Section 1 of the Constitution, and the President, President-Elect, Treasurer and Immediate Past President, Assistant Treasurer, Speaker, Vice-Speaker and the Executive Secretary.*

Section 3. *Organization.*

(a) Immediately following the conclusion of the annual convention, the Board shall organize by electing a Chairman, Vice-Chairman, Secretary, and Committees necessary to its needs.

(b) The Board of Trustees at its organization meeting, by resolution adopted by a majority of the Trustees in office, may designate two Trustees or members, to constitute an Executive Committee. Members of the Committee shall serve until the next organization meeting of the Board and until their successors are elected and qualified. The Executive Committee shall have such

powers and duties as may be defined from time to time by resolution of the Board of Trustees.

Section 4. Meetings.

(a) There shall be at least four regular meetings of the Board of Trustees each calendar year to be held at such time and place as the Board shall determine. Notice of each regular meeting shall be given at least ten days before such meeting.

(b) Special meetings may be called at any time by the Chairman or at the request of seven members of the Board. Notice shall be given at least five days before each special meeting. The notice shall specify the general purpose of and business to be transacted at the meeting, but other business may also be transacted.

(c) Twelve members of the Board shall constitute a quorum.

(d) Notice is given if delivered in person, by telephone, mail or telegram. If mailed, such notice shall be deemed to be delivered when deposited in the United States mail, addressed to a Trustee (and other persons entitled to notice) at his address then appearing on the records of the Association, with postage prepaid, and if given by telegraph, shall be deemed delivered when the telegram is delivered to the telegraph company.

(e) Notice of any meeting and the object or business to be transacted at a meeting of the Board need not be given if waived in writing, or by telegraph, cable, or wireless before, during, or after such meeting. Attendance at any meeting shall constitute a waiver of notice of such meeting except where attendance is for the express purpose of objecting to the transacting of any business because the meeting is not lawfully called or convened.

Section 5. Rights and Duties. In addition to the rights and duties conferred or imposed on the Board elsewhere in the Constitution and Bylaws, the Board shall:

(a) Perform all acts and transact all business for or on behalf of the Association and manage the property and conduct the affair, work and activities of the Association, except as may be otherwise provided in the Constitution or the Bylaws. All resolutions and recommendations of the House of Delegates including the expenditure of funds passed by the House of Delegates, shall be referred to the Board of Trustees which shall determine if the resolutions, recommendations or the expenditures are advisable. If it is decided that the resolution(s), recommendation(s) or the expenditure(s) is inadvisable, the Board shall report, at its earliest convenience, to the House of Delegates the reasons for its action.

(b) Provide for the publication of and determine the editorial policies, in accordance with the policy enunciated by the House of Delegates, of (1) *THE JOURNAL of the State Association*, (2) publications as it may deem expedient, (3) a publication for public information and dissemination and (4) all proceedings, transactions and memoirs.

(c) Appoint an editor or editors for all of the Association's publications.

(d) Employ the Executive Secretary, and fill any vacancy therein, who shall be the person to manage and direct the activities of the Association under the authority granted by the Board.

(e) Have the accounts of the Association audited at least annually.

(f) Make proper financial reports concerning Association affairs to the House at its annual convention.

(g) After thirty days notice, to remove any officer from office after hearing, on charges in writing, upon a vote of three-fourths of the members of the Board.

(h) The Chairman of the Board shall become President Pro Tem in the event of the death, resignation, removal or disability of the President and the President-Elect. As President Pro Tem the Chairman of the Board shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing members to fill these vacancies, who shall serve until the next regular meeting of the House of Delegates, at which time both a President and a President-Elect shall be elected, both of whom shall take office immediately upon their election.

(i) The Board shall fill a vacancy in the office of Treasurer or Assistant Treasurer by an election by the Trustees at the next regular meeting of the Board following the occurrence of such vacancy.

Section 6. The duties of the Alternate Trustee shall be:

(a) To represent the Trustee District when the regularly elected Trustee is not in attendance.

(b) To vote only when the Trustee is not in attendance either in the House of Delegates or in the Board meetings where he represents the regularly elected Trustee.

ARTICLE VII.— SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such Trustee District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies. Trustee districts shall be defined by the House of Delegates.

ARTICLE VIII.—CONVENTION AND MEETINGS

Section 1. The Association shall hold an Annual Convention during which there shall be held such general and section meetings as the Association through its duly constituted officers and committees may provide for.

Section 2. The House of Delegates shall select the place five years in advance for holding the Annual Convention. The time for the convention shall be fixed by the Board, and the Board shall have the power also to change the place for holding the convention where conditions may create difficulties in holding a successful convention at the place designated by the House of Delegates.

Section 3. Special meetings of either the Association or the House of Delegates shall be called by the President upon receipt of a petition signed by thirty delegates or one hundred members. The signed petition shall contain the names of at least ten delegates or thirty-four members from each of at least three Board districts. Upon receipt by the President of such a petition, the President shall within thirty days thereafter issue a call for such special meeting at a time and place to be fixed by the President. The President, in specifying the time of such special meeting, shall fix the same as soon thereafter as reasonable and suitable arrangements can be made.

ARTICLE IX.—OFFICERS

Section 1. The officers of this Association shall be a President, a President-Elect, the Immediate Past President, an Executive Secretary, a Treasurer, an Assistant Treasurer, a Speaker, a Vice-Speaker, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member.

The election process and the rights and duties of the officers are as set forth in the Bylaws.

Section 2. *The officers, except the Trustees and the Executive Secretary, whose election has been provided for elsewhere herein, shall be elected annually. All officers shall serve until their successors are elected and installed.*

Section 3. The officers of this Association with the exception of the Executive Secretary shall be elected by the House of Delegates as the first order of business at the final meeting of the House of Delegates, and no person shall be elected to any such office who has not been an active member of the Association for the preceding two years.

Section 4. *Any officer may be removed from office after a hearing before the Board, on thirty days' notice, on charges in writing, upon a vote of three-fourths of the members of the Board.*

Section 5. *In the event of the death, resignation, removal, or disability of the President, the President-Elect shall succeed to the presidency. In the event of the death, resignation, removal, or disability of both the President and the President-Elect, the Chairman of the Board shall become President Pro Tem and shall perform the duties and obligations as set forth in Article VI, Section 5(h) above.*

Section 6. *A vacancy in the office of Treasurer or Assistant Treasurer shall be filled by an election by the Trustees at the next regular meeting of the Board following the occurrence of such vacancy.*

ARTICLE X.—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of reelection.

ARTICLE XI.—INCOME AND EXPENSES

Funds for carrying on the activities of this Association shall be raised by the following means:

(a) Membership dues to be collected may be collected by the Indiana State Medical Association or by the component county societies. The amount of dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates.

(b) Voluntary contributions.

(c) Revenues derived from the Association's publications.

(d) *Upon recommendation of the Board of Trustees or any other manner approved by the House of Delegates.*

Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Board for approval before final action is taken thereon.

ARTICLE XII.—REFERENDUM

Section 1. A general Meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the

House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

Section 2. The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

ARTICLE XIII.—THE SEAL

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

ARTICLE XIV.—AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Convention, provided that such amendment shall have been presented in open meeting at the previous Annual Convention, and that it shall have been published twice during the year in THE JOURNAL of this Association.

Bylaws

HOUSE ACTION: The following amendments to the revised Bylaws were adopted and will become effective immediately.

CHAPTER III, Section 1—Sections—amended by the addition of (r) Orthopedic Surgery and (s) Emergency Medicine and (t) to read "Any other sections that hereafter may be provided for by the House of Delegates."

CHAPTER IV, Section 2—House of Delegates—amended by adding words "executive secretary or executive director of the larger societies" between the word "society" and the word "is".

CHAPTER IV, Section 3—House of Delegates—Change to read Fifty (50) delegates shall constitute a quorum.

Bylaws

CHAPTER I.—MEMBERSHIP

Section 1. Regular Members. *The term "regular member" as used in these Bylaws shall include Active, Senior, Military Service Member, Public Health Service Member, Disabled Member, Medical Student Member, Interns and Residents, of component county medical societies who hold the degree of Doctor of Medicine or Bachelor of Medicine, or who hold an unrestricted license to practice medicine and surgery. As to Interns and Residents they shall be serving in training programs approved by the Association, or if a Medical Student they shall be enrolled in a medical school approved by the Association. All regular members are entitled to exercise the rights of membership in their county and state associations, including the right to vote and hold office, as determined by their respective county medical society and/or their state association.*

Section 2. *A regular member who is a member in*

good standing of a component county society and who has paid to this Association his annual dues is a member in good standing of the Indiana State Medical Association, provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect.

Section 3. No person whose license to practice medicine has been suspended or revoked or who is under sentence of suspension or expulsion from a component society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association or of a component county society, nor shall he be permitted to take part in any of their proceedings until he has been relieved of such disability.

Section 4. Each member in attendance at the Annual Convention shall register by indicating the component society of which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that convention. No member shall take part in any of the proceedings of an Annual Convention until he has complied with the provisions of this section.

Section 5. *Special Member.* The term "special member" as used in these Bylaws, unless otherwise indicated, shall mean Associate Members and Honorary Members as defined in Section 5 and Section 7 of Article IV of the Constitution of the Indiana State Medical Association. Special members shall not be entitled to vote or hold office in this Association.

CHAPTER II—GENERAL MEETINGS

Section 1. General Meetings shall mean all meetings planned for attendance by all registered members, and shall include those meetings in which guests of registered members or the general public are also invited. The address of the President may be delivered in a General Meeting, and the programs of General Meetings shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program shall be arranged by the Commission on Convention Arrangements, with the sanction and approval of the officers.

Section 2. The General or Section Meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and public.

Section 3. All scientific papers read before the Association or any of the sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board of this Association. Each such paper shall be deposited with the Executive Secretary when read.

Section 4. The Board shall appropriate from the funds of the Association such an amount as in the discretion of the Board shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such Convention. The funds so appropriated shall, upon the approval of the Executive Committee, be expended at the direction of the Commission on Convention Arrangements appointed by the President for the Convention for which the appropriation is made. All money in excess of that

expended for actual expenses incurred shall revert each year to the treasury of the Association.

Section 5. Any of the component member county societies wishing to invite the Indiana State Medical Association to hold its annual meeting in its locality shall submit an invitation in writing at least five years in advance to the Board of Trustees. The Board of Trustees shall make an investigation of the facilities and in turn recommend the location to the annual meetings for concurrence by the House.

CHAPTER III—SECTIONS

Section 1. During the Annual Convention the Association in addition to the general meetings may hold the following section meetings:

- a. Surgical.
- b. Internal Medicine.
- c. Eye, Ear, Nose, and Throat.
- d. Anesthesia.
- e. Family Physicians.
- f. Obstetrics and Gynecology.
- g. Preventive Medicine and Public Health.
- h. Radiology.
- i. Nervous and Mental Diseases.
- j. Pathology and Forensic Medicine.
- k. Pediatrics.
- l. Directors of Medical Education.
- m. Cutaneous Medicine.
- n. College Health Physicians.
- o. Interns and Residents.
- p. Allergy.
- q. Urology.
- r. Orthopedic Surgery.
- s. Emergency Medicine.
- t. Any other sections that hereafter may be provided for by the House of Delegates.

Section 2. The officers of each section shall be a chairman, a vice-chairman, and a secretary, and they shall preside over the meetings of the sections and shall be responsible to the Committee on Scientific Work for the section speakers and papers.

Section 3. The election of officers of the sections shall be the last order of business of the last meeting of the sections during the Annual Convention.

Section 4. No section meeting shall be allowed to conflict with a general meeting.

CHAPTER IV—HOUSE OF DELEGATES

Section 1. The House of Delegates may meet on the day before the date set for the beginning of the general registration of the attendance at the Annual Convention. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the general or section meetings. It shall meet on the last day of the Annual Convention for the election of officers for the ensuing year, and for the completion of any business previously introduced. The order of business shall be arranged as a separate section of the program. Nominations for officers of the Association may be made at any meeting of the House of Delegates.

Section 2. Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members and one for each major fraction thereof; but, irrespective of the number of

members, each component society which has made its annual report and paid its assessments, as provided in this Constitution and Bylaws, shall be entitled to one delegate, except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate and one alternate delegate who shall be a resident of the county he represents as a delegate or alternate delegate and who shall be selected by the physicians residing in such county. *One delegate and one alternate shall be selected by the Indiana Chapter of the American Medical Student Association. The student delegate shall be seated with full power to vote. In the absence of the student delegate, the alternate shall be seated with full power to vote.*

The number of delegates to which each component society is entitled shall be based upon the number of members on record in the office of the Executive Secretary in good standing with current dues fully paid as of December 31 of the preceding year.

All sections listed in Chapter III, Section 1, of these Bylaws shall be entitled to send to the House of Delegates each year one delegate or one alternate delegate without the power to vote.

The names of duly elected delegates and alternates from each component society shall be sent to the Executive Secretary of this Association on or before February 1, prior to the Annual Convention at which such delegates are to serve. No one shall be entitled to a seat in the House of Delegates unless his credential card as a delegate or alternate, properly signed by the secretary of his county medical society, executive secretary or executive director of the larger societies, is presented to the Committee on Credentials at the time of the Annual Convention.

Section 3. Fifty (50) delegates shall constitute a quorum.

Section 4. The House of Delegates shall:

a. Elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

b. Divide the state into Trustee districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, and all members of component county societies, and no others, shall be members of such district societies.

c. Have authority to appoint committees for special purposes from among members of the Association who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and the members of such committees may be present and participate in the debate on their reports.

d. Approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 5. Proposals calling for appropriations of funds by the House of Delegates shall be accompanied by a fiscal note and shall be submitted to the Executive Committee and the Board for review, presentation and recommendation for final action of the House. No proposal calling for appropriations shall be considered if not accompanied by a fiscal note.

Section 6. *At the first meeting the Speaker shall, with the assistance of the President, appoint from the members of the House the Reference Committees and such additional House Committees as the House may approve. Each Committee shall consist of five members unless otherwise provided. The Chairman of each Com-*

mittee shall be appointed by the Speaker, with the assistance of the President. All Committees hereunder shall serve only during the Convention at which they are appointed.

Section 7. All resolutions to be presented to the House of Delegates for action shall be prepared and mailed to the Executive Secretary of the Association so that he will receive them not later than 45 days prior to the meeting of the House of Delegates to which the resolutions will be presented for action.

Provided, that where a resolution has been first submitted to the Committee on Rules and Order of Business together with a written statement setting forth the reasons why said resolution was not mailed to the Executive Secretary more than 45 days prior to the meeting of the House of Delegates and also setting forth in said written statement the reasons why said resolution is of such an emergency nature that it cannot wait until the next meeting of the House, and that said Committee on Rules and Order of Business has approved said resolution for submission to the House, and that each delegate shall be furnished a copy before the next meeting of the House, then this subsection of the Bylaws may be suspended with respect to said resolution upon a two-thirds vote of the House of Delegates.

The Committee on Rules and Order of Business, mentioned above, shall be composed of the chairmen of the various Reference Committees appointed by the Speaker.

Section 8. The final vote on any issue calling for changes in dues or in dues structure shall be by roll call vote. Each member's vote shall be permanently recorded and no suspension of this rule will be allowed on the final vote on such an issue.

CHAPTER V—ELECTION OF OFFICERS

Section 1. The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the last day of the Annual Convention.

Section 2. All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken.

Section 3. The President, President-elect, Treasurer and Assistant Treasurer shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect, Treasurer and Assistant Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates.

Section 4. The officers of the Association shall be installed by taking the following oath of office to be administered by the outgoing President of the Association at the final meeting of the House of Delegates:

Section 5. I, _____, solemnly swear that I shall carry out to the best of my ability, the duties of the office of the Indiana State Medical Association to which I have been elected.

I shall strive constantly to maintain the ethics of the medical profession and to promote the public health and welfare. I shall dedicate myself and my office to improving the health standards of the American people and to do the task of bringing increasingly improved medical care within the reach of every citizen.

I shall uphold the Constitution of the United States of America and of the State of Indiana, the Constitution and Bylaws of the American Medical Association and the Constitution and Bylaws of the Indiana State Medical Association at all times.

I shall champion the cause of freedom in medical practice and freedom for all my fellow Americans. To these duties and obligations, I pledge myself, so help me God.

CHAPTER VI—DUTIES OF OFFICERS

Section 1. The President, or a member designated by him, shall preside at all general meetings of the Association. [and of the House of Delegates] The President shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Executive Committee, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the Trustees in building up the county societies and in making their work more practical and useful.

Section 2. The President-elect's term of office shall be for one year, at the completion of which he succeeds to the presidency. While President-elect, he shall assist the President in the discharge of his duties.

Section 3. The Treasurer shall give bond at the expense of the Association in such an amount as shall be required by the Board. He shall receive all bequests and donations to the Association and shall demand and receive all funds due the Association except accounts due THE JOURNAL in the conduct of its business. The funds of the Association shall be deposited in a depository or depositories designated by the Executive Committee, and withdrawals from such funds shall be made on checks or drafts signed by the Treasurer and the chairman of the Board. He shall present to the House of Delegates annually a report of the receipts and expenditures, and the state of the funds in his hands, and shall subject his accounts to an annual audit by a Certified Public Accountant.

The Assistant Treasurer shall give bond at the expense of the Association in such amount as shall be required by the Board unless he is included in the coverage of a blanket or position bond. In case of death, or incapacity of the Treasurer, he shall succeed to all the duties and rights of the Treasurer until a new Treasurer be elected. In the absence of the Treasurer, he shall attend to the duties and rights of the Treasurer during such absence and he shall also perform such duties of the Treasurer as may be delegated and assigned to him by the Treasurer.

Section 4. The Executive Secretary shall be the directing manager of the Association's headquarters and JOURNAL offices, and shall supervise the work of all salaried employees in the Association offices. Such supervision shall be subject to directives from the House of Delegates, the Board, the Executive Committee, and the President of the Association. He shall discharge the administrative functions of the Association not within the duties of other officers or of committees to perform. He shall assist, at their request, all officers and committees, and shall keep himself informed in regard to non-professional matters affecting the medical profession, for the purpose of keeping himself qualified to perform the services herein mentioned. He shall be responsible for the execution and carrying out of the policies of the

Association and in that connection shall perform all specific tasks committed to him by the committees, the Board, and the officers of this Association. The amount of his salary shall be fixed by the Executive Committee on approval of the Board.

Section 5. The necessary expenses of the above officers incurred in the line of duty herein imposed shall be allowed for in the budget, but excepting the Executive Secretary, this shall not include the expenses of attending the Annual Convention.

CHAPTER VII—BOARD OF TRUSTEES

Section 1. The Board shall meet as follows: 1. The Board shall meet at least once each quarter of the calendar year, the time, date and location to be fixed by the Board. 2. On the day preceding the first day for the scientific meetings of the Annual Convention of the Association. 3. On the last day of the Annual Convention of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, subject to the call of the chairman, or on petition of three Trustees. It shall hold no meeting that will conflict with any meeting of the House of Delegates. It shall elect a chairman, and a clerk, who, in the absence of the Executive Secretary of the Association, shall keep a record of its proceedings. It shall, through its chairman, make an annual report to the House of Delegates. It shall organize itself at the meeting following the final session of the House of Delegates by electing its chairman who shall serve for one year. The chairman of the Board shall be elected by secret ballot. The number of terms of the chairman shall be limited to not more than three in succession.

Terms of Trustees shall begin with the first meeting of the Board following the final session of the House of Delegates at the Annual Session.

Section 2. Each Trustee shall be organizer, peace-maker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of THE JOURNAL which is issued immediately preceding the Annual Convention. The House of Delegates may take such action, if any, as it deems appropriate upon such reports. The necessary expenses incurred by such Trustee in the line of the duties herein imposed may be allowed by the Board on a properly itemized statement, but this shall not be construed to include his expense in attending the Annual Convention of the Association.

Section 3. The Board shall, through its officers and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall study and strive constantly to make each Annual Convention a stepping stone to future ones of higher interest.

Section 4. The Board shall, in connection with the House of Delegates, consider and advise as to the interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

Section 5. The Board shall make careful inquiry into

the condition of the profession of each county in the state and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

Section 6. The Board shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Section 7. The Board shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and Bylaws.

Section 8. In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

Section 9. The Board shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General or Section Meetings shall be referred to the Board without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Trustee, and its decision in all such matters shall be final.

Section 10. The Board shall provide for and superintend all publications of the Association, and shall [have authority to] appoint an editor and [such assistants] an editorial board, as it deems necessary, and fix the amount of their salaries. The proceedings of the Board for the year shall be reported to the House of Delegates at the Annual Convention and be published in the number of THE JOURNAL which immediately precedes the Annual Convention.

Section 11. [In the interim between the meetings of this Association,] The Board shall be the executive body of the Association, with full power to fill vacancies or transact any business that emergencies or the welfare of the Association may require, and perform and exercise all of the rights and duties as specified in the Constitution, Article VI, Section 5(a) through (i), both inclusive.

Section 12. The Board shall at its meeting following the close of the House of Delegates specify the duties and elect two members of the Association, at large, or of the Board, who, with the President, the President-elect, the Immediate Past President, the Treasurer, and the Chairman of the Board, shall constitute and be known as the Executive Committee. If such members of the Executive Committee be not members of the Board they shall not have the power of vote in the Board.

CHAPTER VIII—ORGANIZATION OF ACTIVITIES AND RESPONSIBILITIES

Section 1. The organization of the Association, the performance of which is not provided elsewhere in the Constitution or Bylaws, and is not carried on in the meetings of the Board or of the House of Delegates, or by special committees created by the Executive Committee, the Board or the House of Delegates, may be performed by the following committees and commissions:

- The Grievance Committee
- The Future Planning Committee
- The Medical Legal Committee

The Commissions are as follows:

COMMISSION ON MEDICAL SERVICES

This Commission encompasses the fields of:

- Emergency Medical Services
- Aging
- Public Health
- Governmental Medical Service Programs
- Voluntary Health Agencies
- Sports and Medicine
- Medical Economics and Insurance

COMMISSION ON MEDICAL EDUCATION

This Commission encompasses the fields of:

- Licensure
- Accreditation
- Education Program

COMMISSION ON LEGISLATION

This Commission encompasses the fields of:

- State Legislation
- Federal Legislation

COMMISSION ON CONSTITUTION AND BYLAWS COMMISSION ON PUBLIC RELATIONS

This Commission encompasses the fields of:

- Public Information
- Special Activities
- Interprofessional Relations

COMMISSION ON CONVENTION ARRANGEMENTS

This Commission encompasses the fields of:

- Specialty Medicine

The responsibilities of the Student Loan Committee are transferred to the jurisdiction of the Executive Committee.

The difference between Committees and Commissions is shown in the provision of these Bylaws pertaining to their work and composition.

Section 2. Except as otherwise stated in the Bylaws, a Committee shall consist of not less than 4 nor more than 5 members, appointed from the general membership of the Association and shall be appointed annually by the President. The President shall also appoint the Chairman and the Vice Chairman of each Committee.

Section 3. Each Commission will consist of 15 members appointed by the President, with at least one member from each Trustee district. The original appointees in each commission shall be divided into three groups by lot. The first group shall serve three years; the second, two years; and the third, one year. Thereafter, each incoming President shall appoint five members of each commission to fill the vacancies resulting from the expiration of the terms of members, and such appointments shall be for three years. The President shall also appoint members to fill the unexpired term where any vacancy occurs through death, resignation or otherwise. The President shall also appoint the chairman and

the vice-chairman of each commission.

Section 4. The President shall have the power, with the approval of the Board, to remove any member of any committee or commission where such member, for any reason, does not or cannot work at attempting to perform the duties pertaining to membership on such committee or commission.

Section 5. Unless otherwise provided in these Bylaws, no member of either a committee or a commission shall serve on the same committee or a commission more than two consecutive terms, but this shall not prevent his serving more than two terms if the term of another member intervenes. The time given to the serving of an unexpired term shall not be considered in determining the period within which a member may serve consecutively.

Section 6. Within sixty days after the meeting of the State Convention, the President will call all commissions and committees into a joint meeting in which he will give a statement of the duties and responsibilities of all committees and commissions, call special attention to any immediate problems confronting the Association, and assign such problems or parts thereof to appropriate committees and commissions. In these meetings the commissions may provide for such sub-committees within the separate commissions as they may deem advisable. Each committee or commission shall have the right to call upon other committees, commissions or members of the profession for counsel and advice with respect to its work.

Section 7. Each committee and commission shall have the privilege and is encouraged to have joint meetings with any like committee or commission of the Auxiliary where such like committee or commission exists, for the purpose of coordinating their activities to make them more effective in the medical service of the public and the intent of the Association.

Section 8. Each committee and commission shall have the duty and responsibility of keeping constantly and currently informed on the matters within the area of its special interest and activity; of studying the conditions within that area with the purpose of finding possibilities of improvement; of finding the best solutions it can to the specific problems referred to it; of contributing in

its area to the achievements of the Association as a whole in the protection and improvement of the health of the whole human family and finally of making all its efforts useful by passing on to the Association in the most effective manner possible the results of its studies and activities in its own area of special interests.

Section 9. The President, Executive Secretary, Speaker and Vice-Speaker of the House shall be *ex officio* members of all the foregoing committees and commissions without voting rights where their inclusion on the committee or commission is not otherwise provided for in these Bylaws.

CHAPTER IX—THE EXECUTIVE COMMITTEE

Section 1. The Executive Committee, constituted as provided in Section 12 of Chapter VII of these Bylaws, shall hold its first meeting immediately following the meeting of the Board held at the close of the last meeting of the House of Delegates in the Annual Convention, and shall organize by electing its chairman. Its secretary shall be the Executive Secretary of the Association. It shall meet with the Executive Secretary on the call of the chairman, or of any three members, to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Secretary's office *and such other duties as the Board may specify*. It shall have all jurisdiction with respect to medical defense activities of the Association, and shall be governed by the rules it adopts concerning that activity and by the Bylaws of this Association. It shall make decisions for the Association, including matters pertaining to THE JOURNAL, during the intervals between the meetings of the Board, and shall report its actions to the Board.

Section 2. It shall prepare a budget for the ensuing fiscal year; and all expenditures of the Association, except those otherwise provided for under the Constitution and Bylaws, shall be governed by the budget. No expense not provided for in the budget or otherwise under the Constitution and Bylaws shall be incurred by any officer, commission or committee. A committee, commission or officer may submit a request for funds to meet unusual expenses not included in the annual budget, and the Executive Committee shall have the power, by a two-thirds vote, to amend the budget to provide such funds.

Resolutions

Resolution No. 75-1

Introduced by: John W. Luce, M.D.,
Delegate from LaPorte
County

Subject: CREATION OF A SECTION ON ORTHOPEDIC SURGERY

HOUSE ACTION: Adopted. Referred to Commission on Constitution and Bylaws for study of the question of creation of new sections.

Be it resolved, That Chapter III, Section 1 of the Bylaws, be amended by adding a new line "r" to read "Orthopedic Surgery"; and be it further

Resolved, That the present line "r" be relettered line "s."

Resolution No. 75-2

Introduced by: Section on Allergy
Subject: CREATION OF DEPARTMENT OF ALLERGY AND IMMUNOLOGY AT INDIANA UNIVERSITY SCHOOL OF MEDICINE

HOUSE ACTION: Not adopted.

Whereas, 25-30% of patients seen by pediatricians are for an allergic problem; and

Whereas, More time is lost from school by children and teenagers because of allergic disease than from any other cause; and

Whereas, There are an estimated 50,000 asthmatics in Marion County alone; and

Whereas, Every state surrounding Indiana has medical schools with departments of allergy and immunology and accredited training programs in allergy and immunology; and

Whereas, Indiana University School of Medicine has no such department of allergy and immunology nor any training program in this subspecialty; and

Whereas, Because of this, graduates of Indiana University School of Medicine are deficient in their ability to diagnose and treat allergic disease to the detriment of 15% of the population of Indiana; and

Whereas, Also because of Whereas No. 5, those interested in furthering their training in allergy and immunology must leave the state for this training and seldom return to Indiana to practice; and

Whereas, This has created a severe shortage of trained allergists in the state so that patients must frequently travel many miles and wait long periods of time to be seen and evaluated by properly trained men so that many go with-

out proper care because of this scarcity of doctors trained to understand and care for these specialized problems; and

Whereas, Since allergy training now consists of a conjoint Board of Allergy and Immunology and is a subspecialty in either internal medicine or pediatrics, and consists of two years of training in either of these specialties followed by two years training in allergy and immunology; therefore, be it

Resolved, That the House of Delegates of the Indiana State Medical Association vote favorably on a resolution to use whatever means possible to overcome this deficit which degrades Indiana University School of Medicine as a proper training center for doctors and is not in the true interest of the citizens of Indiana; and be it further

Resolved, That a Department of Allergy and Immunology and residency or fellowship training program in the same be created at the Indiana University School of Medicine; and be it further

Resolved, That the members of the Section on Allergy of the Indiana State Medical Association promise their support in helping train these men, inasmuch as properly treated allergy patients seldom require hospitalization (such as the prevention of status asthmaticus in most patients by proper allergic management) and most allergic problems are office or clinic problems; and be it further

Resolved, Therefore, that we shall be happy to assist in proper preceptorship programs and lectures and conferences to supplement residency training programs so that Indiana University School of Medicine will not be looked upon as a second-rate medical school because of this. Ultimately, the citizens of Indiana will greatly benefit from this and this is the reason the taxpayers support a medical school in Indiana.

Resolution No. 75-3

Introduced by: Vanderburgh County
Medical Society

Subject: TRAVEL EXPENSE
HOUSE ACTION: Adopted.

Whereas, Financial stresses and fiscal restraints have been imposing restrictions and retrenchments upon programs of the Association; and

Whereas, Physicians generally practice economies in their personal expenditures, including air travel at tourist rates rather than first-class fares; therefore, be it

Resolved, That it be the policy of the Indiana State Medical Association that air travel costs incurred on business of the Association be reimbursed at tourist or economy rates, unless some physical ailment of the traveler makes this in-

advisable for reasons of health or in cases of bona fide emergency trips when tourist accommodations are not available; and be it further

Resolved, That the Indiana delegation to the American Medical Association be instructed to work for the adoption of a similar policy for travel costs by the American Medical Association.

Resolution No. 75-4

Introduced by: Vanderburgh County
Medical Society

Subject: LOCATION AMA MEETINGS

HOUSE ACTION: Adopted.

Recommendation that AMA delegates introduce this resolution at the next AMA meeting.

Whereas, The American Medical Association has been espousing fiscal restraint for some time; and

Whereas, Drastic retrenchment of vital Association activities has recently been invoked; and

Whereas, Significant and sustained economies could be quickly achieved with enhanced efficiency for the Association merely by holding most meetings in Chicago where the headquarters and staff are already situated; therefore, be it

Resolved, That until such time as the Association's resources permit the luxury of travel and transportation of staff and equipment, all meetings be held in Chicago, except for government-related activities which may be better served by a Washington location; and be it further

Resolved, That scheduled sessions at distant sites be rescheduled for Chicago unless compelling and persuasive reasons can be advanced with appropriate fiscal data.

Resolution No. 75-5

Introduced by: Vigo County Medical Society

Subject: ISMA MEMBERS INSURANCE PLAN

HOUSE ACTION: Adopted as amended.

Whereas, The cost of malpractice insurance has spiraled to a point where such insurance is beyond the reach of many physicians; and

Whereas, Many physicians are unable to purchase such insurance even at these unreasonable premiums; and

Whereas, Most physicians carry other insurance, such as life, fire, theft, car, personal liability, homeowners, etc.—all of which are profitable insurances for the insurance companies; and

Whereas, The insurance companies are unwilling to compensate the loss they may suffer from malpractice insurance with these highly profitable insurances; therefore, be it

Resolved, That the Indiana State Medical Association through its Commission on Medical Economics and Insurance shall further study the matter of an insurance program for all its members which would permit its members to purchase all types of insurance through a self-insurance program of the Indiana State Medical Association.

Resolution No. 75-6

Introduced by: Commission on Aging
Subject: DEPARTMENT OF GERONTOLOGY—I.U. SCHOOL OF MEDICINE
HOUSE ACTION: Not adopted.

Whereas, At the present time there is no department of gerontology at Indiana University School of Medicine; and

Whereas, There should be lectures in the freshman or sophomore year on the problems of the aged and aging; and

Whereas, There is a need for a clerkship in the junior year and/or an elective in the senior year in gerontology; and

Whereas, There is an added need for a residency in gerontology; and

Whereas, Externships in nursing homes for junior and senior medical students are of benefit to both the student and the nursing home; therefore, be it

Resolved, That medical students be exposed to gerontology through creation of the above; and, be it further

Resolved, That junior and senior medical students and/or interns or residents in gerontology and junior and senior dental students give regular physical and dental exams to nursing home residents.

Resolution No. 75-7

Introduced by: Ninth District Medical Society
Subject: TEL-MED
HOUSE ACTION: Adopted as amended. Referred to the Board of Trustees to determine the feasibility of funding and continuance of Tel-Med and directed to ask for voluntary contributions.

Whereas, Indiana State Medical Association's Tel-Med program has become its greatest and most successful public relations service; and

Whereas, An average of 800 tapes a day are requested and played; and

Whereas, Schools, church organizations and the general public at large have accepted and used this service; and

Whereas, No monetary funding to continue the program was provided from the House of Delegates; now, therefore be it

Resolved, That the Board of Trustees determine the feasibility of funding and continuance of Tel-Med and be directed to ask for voluntary contributions.

Resolution No. 75-8

Introduced by: Ninth District Medical Society
Subject: MEDICAL MUSEUM
HOUSE ACTION: Adopted as amended. Referred to Board of Trustees.

Whereas, The Medical Section of the Indiana State Historical Society is converting the old Pathology Building at the Central State Hospital into a very fine and unique museum of Indiana medicine; and

Whereas, Indiana State Medical Association supported the start of this program with a grant; and

Whereas, No regular source of funding has been provided, now, therefore, be it

Resolved, That the Board of Trustees investigate voluntary contributions for this endeavor.

Resolution No. 75-9

Introduced by: Dubois County Medical Society
Subject: FEE INEQUALITY
HOUSE ACTION: Following Substitute Resolution No. 75-9, as amended, adopted in lieu of No. 75-9.

Whereas, In the interest of improved communications between physicians, the Medicare/Medicaid intermediary and the uninformed consumer; now, therefore, be it

Resolved, That the Indiana State Medical Association, through its Board of Trustees and its Commissions, work to properly inform the Indiana State Medical Association membership of their fee profiles held by the intermediary insurance carrier; and be it further

Resolved, That ISMA and its Board work for elimination of different fee schedules based on geographical regions; and be it further

Resolved, That the manner in which this is accomplished be to the benefit of both the physician and the patient.

Resolution No. 75-10

Introduced by: Randolph County Medical Society
Subject: SECTION ON EMERGENCY MEDICINE
HOUSE ACTION: Resolution No. 75-10 and Resolution No. 75-12 (identical resolutions) were combined and adopted.

Whereas, Emergency medical care has become a predominant part of the medical care delivery system in Indiana and throughout the nation; and

Whereas, Increasing numbers of physicians are specializing in emergency medical care as their practice specialty; and

Whereas, The American Medical Association, cognizant of the import and

critical need for physician input into developing local programs in emergency medical services, has an active Commission on Emergency Medical Service; and

Whereas, The Commission on Emergency Medical Service of the Indiana State Medical Association was the prime mover in developing legislation concerning emergency medical service in Indiana; and

Whereas, The American College of Emergency Physicians is also an active body on the national scene; now, therefore be it

Resolved, That the House of Delegates of the Indiana State Medical Association establish as an official section of the Association a Section on Emergency Medicine.

Resolution No. 75-11

Introduced by: The Marion County Medical Society
Subject: Recognition of Governor Bowen and General Assembly for Passage of HB 1460
HOUSE ACTION: Adopted. Governor Bowen and the General Assembly are to be commended for their efforts.

Whereas, The General Assembly and the Governor of the State of Indiana have passed progressive legislation designed to aid in the alleviation of the medical profession's liability crisis in the state of Indiana; and

Whereas, The citizens of Indiana are best served by a working medical profession; and

Whereas, The members of the General Assembly of the State of Indiana acted in the best interest of the citizens they represent by fairly considering the factual information presented to them; therefore be it

Resolved, That the Indiana State Medical Association convey this expression of appreciation and respect to each member of the General Assembly and the Governor for their work in behalf of the citizens of the State of Indiana.

Resolution No. 75-12

Introduced by: The Marion County Medical Society
Subject: Creation of Section on Emergency Medicine
HOUSE ACTION: Resolution No. 75-12 and Resolution No. 75-10 (identical resolutions) were combined and adopted.

Whereas, Emergency medical care has become a predominant part of the medical care delivery system in Indiana and throughout the nation; and

Whereas, Increasing numbers of physicians are specializing in emergency

medical care as their practice specialty; and

Whereas, The American Medical Association, cognizant of the import and critical need for physician input into developing local programs in emergency medical services, has an active Commission on Emergency Medical Service; and

Whereas, The Commission on Emergency Medical Service of the Indiana State Medical Association was the prime mover in developing legislation concerning emergency medical service in Indiana and

Whereas, The American College of Emergency Physicians is also an active body on the national scene; therefore be it

Resolved, That the House of Delegates of the Indiana State Medical Association establish as an official section of the Association a Section on Emergency Medicine.

Resolution No. 75-13

Introduced by: The Marion County Medical Society

Subject: DRUG SUBSTITUTION

HOUSE ACTION: Following Substitute Resolution No. 75-13 adopted in lieu of No. 75-13

Whereas, The physician must have ultimate responsibility for the care of his patients; and

Whereas, An essential part of patient care is the use of pharmaceutical preparations; and

Whereas, The American Medical Association has encouraged members of the association to support actively state legislation to prohibit drug substitution without physician approval, be it therefore

Resolved, The Indiana State Medical Association actively support anti-substitution legislation.

Resolution No. 75-14

Introduced by: The Marion County Medical Society

Subject: AMA Policies on Medical Information to Lay Press

HOUSE ACTION: Adopted.

Recommendation that the AMA Delegates refer this resolution to the AMA.

Whereas, Articles in lay publications meant to be informational to the public in general are increasingly being inappropriately applied by patients to their individual situations; and

Whereas, Physicians are increasingly placed in jeopardy by their patients who accept these broad presentations as personally applicable and contrary to their physician's treatment; and

Whereas, Publications and news releases of the American Medical Association are not distributed to members

in advance of their wide distribution; and

Whereas, Publications and news releases of the American Medical Association have presented articles of this deleterious nature; therefore be it

Resolved, That the Indiana State Medical Association seek from the American Medical Association adoption of a publication policy which requires advance distribution of information to physicians which may be applied by members of the public without consultation of their physician or may imply inadequacy of treatment delivered in accord with convention.

Resolution No. 75-15

Introduced by: The Marion County Medical Society

Subject: Recognition of members for efforts toward passage of HB 1460

HOUSE ACTION: Not adopted.

Whereas, The General Assembly and the Governor of the State of Indiana have passed aggressive legislation designed to aid in the alleviation of the medical professional liability crisis in Indiana; and

Whereas, Members of the Indiana State Medical Association provided leadership in identifying and communicating the factual information to the General Assembly; and

Whereas, The members of the General Assembly acted in the best interest of the citizens of the State of Indiana by considering the factual information presented to them; and

Whereas, These members of the Indiana State Medical Association endured personal hardship in behalf of their fellow physicians without expectation of recompense or recognition; therefore be it

Resolved, That this Association recognize Dr. William R. Cast, Dr. Anthony Lasich, Dr. Paul Muller, Dr. Gilbert Wilhelmus, and Dr. J. William Wright, Jr., and convey its deep appreciation by sending to each an inscribed copy of this resolution; and be it further

Resolved, That this recognition be preserved in time by causing this resolution to be published in THE JOURNAL of the Indiana State Medical Association.

Resolution No. 75-16

Introduced by: Board of Trustees

Subject: \$1.00 DUES INCREASE FOR AUXILIARY SUPPORT

HOUSE ACTION: Adopted.

Whereas, To assist the Indiana State Medical Association in its program for medical education, the Auxiliary with its many and varied projects raised \$50,037 for AMA-ERF, thus earning for In-

diana a 1974 State Merit Award, placing 13th nationally in per capita contribution; and

Whereas, To assist the Indiana State Medical Association in its programs of medicine and public health the Auxiliary has promoted and assisted with programs for all ages beginning with prenatal clinics, well-baby clinics, immunization action month (IAM), day care centers, and selected child abuse and neglect (SCAN) for children, to youth organizations, camp for crippled children, and drug abuse for teenagers, to planned parenthood, blood pressure clinics, blood bank and telephone hot line for adults, to nursing home visitation and Meals on Wheels for the elderly; and

Whereas, To assist the Indiana State Medical Association in a most important endeavor, this current year the Auxiliary promoted and participated in many legislatively oriented activities, such as writing letters, telephone committees, bus trips, coffees for legislators and people of the community, in addition to its annual Legislative Day which has been most successful in establishing rapport with our legislators; and

Whereas, To continue to assist the ISMA by uniting the wives of members, by coordinating and advising constituent auxiliaries, by expansion of area workshops, by sending delegates to educational meetings and by bringing educational programs and speakers to our state requires increasingly more funds; and

Whereas, The activities of the Woman's Auxiliary are beneficial to all members of the ISMA; now, therefore, be it

Resolved, That the House of Delegates replace the annual grant of \$1,000 to the Woman's Auxiliary with a \$1.00 increase in ISMA membership dues to be allocated annually to the Auxiliary for assistance in its programs.

Resolution No. 75-17

Introduced by: Board of Trustees

Subject: MEDICAL EXAMINER

HOUSE ACTION: Adopted as amended.

Whereas, In many instances law officials experience difficulty in determining a cause of death; now, therefore, be it

Resolved, That the Association cause to be introduced in the 1976 General Assembly a bill to create a medical examiner system in the state of Indiana.

Resolution No. 75-18

Introduced by: Martin J. O'Neill, M.D.

Subject: M.D. ON SPECIAL EDUCATION ADVISORY COMMITTEE

HOUSE ACTION: Following Substitute

Resolution No. 75-18 adopted in lieu of No. 75-18

Whereas, The Special Education Act of 1965 mandated the education of all handicapped children within the local community; and

Whereas, The handicapping afflictions are often multiple and require programs involving multiple disciplines; and

Whereas, Such programs often have a bearing on the child's physical well-being; now, therefore be it

Resolved, The Indiana State Medical Association urges all agencies providing programs for the handicapped, including the State Department of Public Instruction, to seek consistent appropriate medical consultation; and be it further

Resolved, The Indiana State Medical Association believes that this will be most effectively accomplished by physician members on special education advisory committees at all levels.

Resolution No. 75-19

Introduced by: Section on Ophthalmology and Otolaryngology

Subject: EXPANSION OF PARAMEDICAL SERVICES

HOUSE ACTION: Referred to Board of Trustees for further study by an appropriate committee or commission.

Whereas, In some parts of the country there have been attempts by optometrists and other paramedical professionals to enlarge their professional areas of practice and responsibility to an extent unwarranted by their training and experience; and

Whereas, Such attempts, if successful, would pose a serious threat to the health and welfare of the general public; now, therefore, be it

Resolved, That the Indiana State Medical Association reaffirms its opposition to any legislation that would authorize non-physicians to engage in the diagnosis or treatment of disease or injury, or the diagnosis of the absence of disease or injury, in conflict with the public interest; and be it further

Resolved, That the Indiana State Medical Association unequivocally opposes and seeks the defeat of any legislation that would extend the scope of any allied health profession into these areas of the practice of medicine.

Resolution No. 75-20

Introduced by: Section on Ophthalmology and Otolaryngology

Subject: USE OF SUPPORT PERSONNEL

HOUSE ACTION: Following amended Substitute Resolution No. 75-20 adopted in lieu of Resolution No. 75-20 and Resolution No. 75-31.

Whereas, The use of medical supportive personnel by physicians is necessary and desirable; and

Whereas, Physicians are legally responsible for the acts of persons in their employment; now, therefore be it

Resolved, That the Indiana State Medical Association reaffirms that the health and welfare of the public requires that physicians' services be made more available to patients needing them by appropriate use of medical supportive personnel; and be it further

Resolved, That the Indiana State Medical Association support legislation which would authorize physicians to use appropriately trained supportive personnel under physician supervision; and be it further

Resolved, That these may include graduates of physician assistant training programs certified by the State Medical Licensing Board and provide that the physician be ultimately responsible for the care of the patient.

Resolution No. 75-21

Introduced by: Section on Ophthalmology and Otolaryngology

Subject: MORATORIUM ON CREATION OF NEW LICENSING BODIES

HOUSE ACTION: Adopted.

Whereas, There is a continuing trend toward state licensing of professionals in paramedical fields such as nursing, optometry, dentistry, psychology, physical therapy, podiatry, pharmacy, audiology and chiropractic; and

Whereas, Licensure and self-regulating board status is being sought by professionals in other fields of paramedical practice; now, therefore, be it

Resolved, That the Indiana State Medical Association opposes legislation that would involve granting licensure and self-regulating board status (as opposed to mere certification) to any additional field of paramedical practice.

Resolution No. 75-22

Introduced by: Section on Ophthalmology and Otolaryngology

Subject: EXCLUDING PHYSICIANS AS PRIMARY CARE PHYSICIANS

HOUSE ACTION: Adopted as amended.

Whereas, Paramedical professionals not regulated by the State Medical Licensing Board are attempting to establish themselves as the sole source of providing primary care in their respective fields of practice at the point of entry into the medical care delivery system; and

Whereas, Such attempts, if successful, would make it difficult for persons needing physicians' services to obtain such services expeditiously; now, therefore, be it

Resolved, That the Indiana State Medical Association opposes legislation that would tend in any way to exclude physicians from providing primary care in any field of practice at the point of entry into the medical care system.

Resolution No. 75-23

Introduced by: Section on Ophthalmology and Otolaryngology

Subject: LIMITATION OF THE HEALTH CARE PROFESSIONAL

HOUSE ACTION: Adopted as amended.

Whereas, There is an increasing tendency on the part of the health care professionals not regulated by the Indiana Medical Licensing Board to observe patients exhibiting obvious symptoms of pathology over an extended period of time and to subject such patients to prolonged therapy prior to referring them to a physician; and

Whereas, This has led to numerous incidents of serious health impairments that might have been avoided had such patients obtained prompt medical attention; now, therefore, be it

Resolved, That the Indiana State Medical Association support legislation that would prohibit health care professionals not regulated by the Indiana Licensing Board from representing that they are qualified, or from holding themselves out to the public as being qualified, to diagnose the presence or absence of any disease or pathological condition; and be it further

Resolved, That the Indiana State Medical Association support legislation that would require or encourage such health care professionals promptly to refer patients to physicians when they detect the presence of the condition that may be pathological.

Resolution No. 75-24

Introduced by: Fort Wayne-Allen County Medical Society

Subject: PSRO POLICY — RECONSIDERATION

HOUSE ACTION: Adopted as amended.

Whereas, The House of Delegates of the Indiana State Medical Association has gone on record as opposing PSRO; and

Whereas, The above action has mandated that every official committee, commission and organ of the Indiana State Medical Association, including its Board of Trustees, cannot officially participate in any endeavor that concerns itself with PSRO; and

Whereas, There are organizations already formed concerning themselves with PSRO activities and who have interested physicians on their boards but no official representation from organized med-

icine; now, therefore, be it

Resolved, That this House of Delegates of Indiana State Medical Association continue its opposition to PSRO in principle; and be it further

Resolved, That this House of Delegates of the Indiana State Medical Association reconsider its attitude toward PSRO involvement so that ISMA may have input and some control over policy and activity which will vitally affect each of its practicing members.

Resolution No. 75-25

Introduced by: Fort Wayne-Allen County Medical Society

Subject: RESCIND RESOLUTION NO. 62-26

HOUSE ACTION: Not adopted.

Whereas, Indiana Blue Cross-Blue Shield, by fiat, determines what constitutes usual and customary charges; and

Where, Fee profiles are then compiled on defined geographic areas, resulting in unrealistic profiles when applied to actual usual and customary fees in a particular area; and

Whereas, This results in a deterioration of physician-patient relationships when fees are disallowed; and

Whereas, This represents economic discrimination against patient and physician; now, therefore, be it

Resolved, The Indiana State Medical Association rescind Resolution 26.

Resolution No. 75-26

Introduced by: Fort Wayne-Allen County Medical Society

Subject: COLLECTIVE BARGAINING

HOUSE ACTION: Adopted as amended.

Whereas, Third party payers, i.e., governmental or private, now capriciously and arbitrarily exact controls over physicians through their payment mechanisms by the use of physician profiles, both individually and collectively; and

Whereas, Third party payers use sophisticated methods to determine these fee levels, such as the economic index, assignment of benefits, percentile applications, wage-price freeze and other such mechanisms, in equating and determining the value of physician service; and

Whereas, The American Medical Association has established a Department of Negotiations; now, therefore, be it

Resolved, That the Indiana State Medical Association obtain more detailed information from the American Medical Association Department of Negotiations concerning its function and implementation.

Resolution No. 75-27

Introduced by: Fort Wayne-Allen County Medical Society

Subject: HONORARY MEMBERSHIP — MR. LARRY L. PICKERING

HOUSE ACTION: Adopted.

Whereas, Larry L. Pickering has served with distinction as the executive director for the Fort Wayne-Allen County Medical Society for 14 years; and

Whereas, He has earned the respect and admiration of all members of the Fort Wayne-Allen County Medical Society and other physicians and other directors and or secretaries of other Medical Societies throughout the state of Indiana; and

Whereas, He has served as executive director of the Fort Wayne Medical Education Program, a part of the statewide medical education system; and

Whereas, His service as executive director has led to the development of outstanding community health care facilities, and because of his highly meritorious service which he has rendered the profession of medicine in Indiana; now, therefore, be it

Resolved, That this House of Delegates, in accordance with Article IV, Section 7, of the Constitution of the Indiana State Medical Association, unanimously elect Larry L. Pickering an honorary member of the Indiana State Medical Association.

Resolution No. 75-28

Introduced by: Fort Wayne-Allen County Medical Society

Subject: USE OF HEALTH INSURANCE DOLLARS

HOUSE ACTION: Not adopted.

Whereas, Indiana Blue Cross-Blue Shield has initiated an Indiana physicians survey in cooperation with Health Services Management, Inc., and various Indiana Health Planning Councils; and

Whereas, The survey was conducted without official consent of the Indiana State Medical Association and its component district and county medical societies; and

Whereas, This survey was alleged to have cost thousands of dollars to conduct; and

Whereas, This information could have been obtained at little or not cost through the Indiana State Medical Association and its component district and county medical societies; now, therefore, be it

Resolved, The Indiana State Medical Association make known to the citizens of Indiana and the Indiana Insurance Commissioner, its strong displeasure over this extravagant and wasteful use of health insurance dollars.

Resolution No. 75-29

Introduced by: Section on Ophthalmology and Otolaryngology

Subject: OPPOSITION TO HEW REGULATIONS ON FEES

HOUSE ACTION: Adopted.

Whereas, The U. S. Department of Health, Education, and Welfare has issued a ruling respecting Medicare reimbursements for physicians' services, which ruling was published in the Federal Register on June 16, 1975; and

Whereas, Said ruling would limit Medicare reimbursements to the lower of the following: the physician's usual and customary fee during the calendar year 1974; the prevailing fee in the relevant geographical area during the calendar year 1974; or the prevailing fee in the relevant geographical area for the calendar year 1971 with an economic index adjustment of 1.1793; and

Whereas, Said ruling, by gearing Medicare reimbursements in part to the physician's usual and customary fee, discriminates between the Medicare patients of one physician and the Medicare patients of another, in that both have been subject to the same Social Security taxes but are nevertheless receiving disparate benefits; and

Whereas, Said ruling, by gearing Medicare reimbursements in part to the prevailing fee in the relevant geographical area, discriminates between patients utilizing physicians' services in one area and patients utilizing physicians' services in another area, in that both have been subject to the same Social Security taxes and are nevertheless receiving disparate benefits; and

Whereas, Said ruling, by gearing Medicare reimbursements in part to the fee prevailing in the relevant geographical area during the calendar year 1971, incorporates mandatory price stabilization concepts and policies that have been discredited and that no longer apply to any other sector of the economy; therefore, be it

Resolved, That the Indiana State Medical Association hereby objects to the ruling of the U. S. Department of Health, Education and Welfare respecting Medicare reimbursements for physicians' services published in the Federal Register on June 16, 1975, as being unfair and discriminatory.

Resolution No. 75-30

Introduced by: Fort Wayne-Allen County Medical Society

Subject: CANCER SOCIETY STATEMENTS

HOUSE ACTION: Adopted as amended.

Whereas, A recent publication of the American Cancer Society titled "American Cancer Society Policy Statement on

the Surgical Treatment of Breast Cancer" was reviewed by the Board of Trustees of the Fort Wayne-Allen County Medical Society, and

Whereas, The contents of said statement intended for distribution to the lay public was more confusing than educational, was quasi-professional in tone, and seemed to cross that tenuous border between concise lay education and medical instruction; now, therefore, be it

Resolved, That the Indiana State Medical Association requests that the American Cancer Society get adequate and verified information before such public statements are released.

Resolution No. 75-32

Introduced by: Board of Trustees

Subject: DUES INCREASE

HOUSE ACTION: Following Substitute Resolution 75-32 as amended adopted in lieu of Resolution No. 75-32 and Resolution No. 75-34

Whereas, The dues of 1975 have reflected \$10.00 for legislative activity and a \$10.00 payment for public information; and

Whereas, there is an obvious need for increased legislative activity, especially in the ensuing legislative session and testing of the constitutionality of the professional liability law; and

Whereas, A deficit of \$81,604.08 was created by our legislative effort on House Bill 1460; and

Whereas, There is an increased cost of what could be called "housekeeping;" i.e., salary increases and payment to pension plans, as well as increased cost of living; now, therefore, be it

Resolved, That a dues increase of \$30.00 be instituted to reflect a \$20.00 increase in payment of legislative activity and a \$10.00 increase for "housekeeping," retaining last year's assessment of \$10.00 for legislation and \$10.00 for public information.

Resolution No. 75-33

Introduced by: St. Joseph County Medical Society

Subject: HONORARY MEMBERSHIP — MR. HARRY C. DAVIS

HOUSE ACTION: Adopted.

Whereas, Harry C. Davis has served with distinction and dedication as the executive secretary for the St. Joseph County Medical Society for over 34 years; and

Whereas, He has earned the respect and admiration of the members of the St. Joseph County Medical Society, other physicians and other medical directors and/or executive secretaries of other medical societies, not only in the state of

Indiana but throughout the country; and

Whereas, In addition to his service as executive secretary, he organized and maintained many business services to the community and to the individual area physicians such as Professional Management Service, Doctors Business Bureau, Telephone Answering Service, Radio Page of Michiana, Medical Assistants Association and teaching programs for the Medical Assistants Association; and

Whereas, His service and devotion as executive secretary have been instrumental in the development of better community health care, and because of his outstanding meritorious service to the profession of medicine in St. Joseph County and the state of Indiana and to his colleagues throughout the country; now, therefore, be it

Resolved, In recognition of his long, devoted and faithful service to the medical profession, this House of Delegates, in accordance with Article IV, Section 7, of the Constitution of the Indiana State Medical Association, unanimously elects Harry C. Davis as Honorary Member of the Indiana State Medical Association.

Resolution No. 75-35

Introduced by: St. Joseph Medical Society

Subject: VALID PATIENT-PLAINTIFF CLAIMS UNDER H.B. 1460

HOUSE ACTION: Referred to the Board of Trustees to send to Indiana State Study Committee.

Whereas, The patient-plaintiff who has an injury as a result of medical treatment may be uninformed of points of law; and

Whereas, H.B. 1460 provides that the Medical Review Panel consider evidence in "written form only," largely consisting of medical records of the usual type, which, in most instances, should provide the panel with adequate information to decide if the evidence in the claim does or does not support the conclusion that the defendant or defendants failed to meet the applicable standard of care as charged in the complaint or, in other words, to decide if malpractice does or does not exist; and

Whereas, Patient-plaintiffs with obviously valid claims are not well served by the requirement that they elect to pay the attorney on a per diem or contingency fee basis at the time of employment; now, therefore, be it

Resolved, That ISMA Board of Trustees seek to introduce legislation to postpone such a determination until after the Medical Review Panel has met, reviewed available information and indicated if there is an obviously valid claim.

Resolution No. 75-36

Introduced by: Vanderburgh County Medical Society

Subject: HONORARY MEMBERSHIP — MR. ARTHUR P. TIERNAN

HOUSE ACTION: Adopted.

Whereas, Arthur P. Tiernan was Executive Secretary of the Vanderburgh County Medical Society for 22 years, and was one of the pioneer medical society executives in Indiana, and

Whereas, Mr. Tiernan served capably and well in support of the interests of the medical profession at county, state and national levels, and

Whereas, He devoted his talents and energies likewise to programs of civic and public concern, and

Whereas, At the time of his retirement and election to the position of Executive Secretary Emeritus in 1970, he was the Senior county medical society executive secretary in the state; now, therefore, be it

Resolved, That Arthur P. Tiernan be elected to Honorary Membership in the Indiana State Medical Association in recognition of his outstanding service to the profession and the community as executive secretary of the Vanderburgh County Medical Society.

Resolution No. 75-37

Introduced by: Lake County Medical Society

Subject: CLAIMS MADE TYPE OF PROFESSIONAL LIABILITY INSURANCE

HOUSE ACTION: Adopted as amended.

Whereas, The Indiana Professional Liability Insurance Law has been passed by the 1975 General Assembly and is now in effect; and

Whereas, Some of the major underwriters of professional liability insurance in the state, notably the St. Paul Mercury Indemnity Company, have now decided to offer a claims-made form of coverage in lieu of occurrence type coverage; and

Whereas, The claims-made form of coverage has been widely misunderstood, and poorly explained, resulting in opposition to it among many physicians, even though it is frequently offered at more acceptable premium rates; and

Whereas, The actual coverage provided by claims-made plans, differs from occurrence type only in the period of time protection is provided; now, therefore be it

Resolved, That the Indiana State Medical Association continue to investigate all forms of acceptable professional liability insurance in order to satisfy the individual needs of each practicing physician.

Resolution No. 75-38

Introduced by: Board of Trustees

Subject: HEW REGULATIONS

HOUSE ACTION: Adopted as amended.

Whereas, The Department of Health, Education, and Welfare by regulation has ordered a rollback in physicians' fees lower than those paid during year 1975; and

Whereas, Legislation has been introduced into the Congress to prevent the rollback; now, therefore, be it

Resolved, That the Indiana State Medical Association urges the American Medical Association on behalf of its membership to take all action necessary (including legal) to have this regulation withdrawn if Congress fails to take action on this matter within a reasonable period of time.

(Fiscal note—Not having had experience in this type of litigation, we would hope the Board of Trustees could supply a cost estimate.)

Resolution No. 75-39

Introduced by: Dearborn-Ohio County Medical Society

Subject: HEALTH CARE PROVIDER CONSORTIUM

HOUSE ACTION: Adopted as amended.

Whereas, It has been mandated by Congress that Public Law 93-641 will determine the direction of total health care for the citizens of the United States in the foreseeable future; and

Whereas, Various state organizations of Health Care Providers, including the Indiana State Dental Association, Indiana State Hospital Association, Indiana Optometric Association, et al., have banded together in a consortium to provide input and direction to the implementation of Public Law 93-641; and

Whereas, The date of implementation of Public Law 93-641 is Jan. 1, 1976; therefore be it

Resolved, That the ISMA actively participate in the formation of health serv-

ice areas governing boards at the state level and encourage and support the membership to become involved at the local level and become familiar with the law; and be it further

Resolved, That ISMA actively oppose the law by all legal means in those areas where it interferes with the proper delivery of health care.

Presidential Resolution

HOUSE ACTION: Adopted by acclamation.

Whereas, Gilbert Meyer Wilhelmus, M.D., president of the Indiana State Medical Association 1974-75, assumed leadership of the association at a time when the problems besetting medicine were many and numerous; and

Whereas, Dr. Wilhelmus, with clarity and foresight, outlined in his inaugural address the objectives and goals he intended to establish for the association; and

Whereas, He decisively and diligently dedicated the energies and activities of the association and of himself to achieve the goals; and

Whereas, He mobilized talents and resources not only within the association, but also from allied organizations and from many persons and groups with related interests; now therefore, be it

Resolved, That the Indiana State Medical Association express its appreciation and gratitude to Dr. Wilhelmus and his family for the many hours and days he has spent in serving the association; and be it further

Resolved, That he be commended for his part in achieving the notable accomplishments of the past year; and be it further

Resolved, That the association express its hope that he will continue his vigorous participation in the affairs of organized medicine.

Resolution to Staff and Facilities

HOUSE ACTION: Adopted by acclamation.

Whereas, A successful 126th Annual Convention of the Indiana State Medical Association is drawing to a close; and

Whereas, The staff of the Indiana State Medical Association has, as usual, labored long and conscientiously in assisting the officers and Convention Arrangements Commission in planning and overseeing that the Convention has been conducted as an effective and efficient Convention operation; and

Whereas, In the long weeks of preparation preceding the Convention, the French Lick-Sheraton staff exhibited an excellent spirit of help; and

Whereas, The staff of the Indiana State Board of Health has also industriously labored in aiding the program plans of the sections and general meetings; now, therefore, be it

Resolved, That this House of Delegates extend thanks to the ISMA staff; and be it further

Resolved, That this House also extend thanks and appreciation to the staffs of the French Lick-Sheraton Hotel and to the Indiana State Board of Health.

A communication from Mrs. K. O. Neumann was read. She expressed gratitude for the resolution from the 1974 House of Delegates honoring her late husband, Kenneth O. Neumann, M.D.

Place of Future Annual Conventions

1976—Indianapolis—October 9-14

1977—Indianapolis—October 10-14

1978—French Lick—October 14-19

1979—Indianapolis—October 8-10

1980—Indianapolis—dates to be set by Board of Trustees

Adjournment

The House of Delegates adjourned sine die at 4:05 p.m., Wed., Oct. 22, 1975.

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Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be consid-

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Vol. 68

No. 12



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The JOURNAL of the INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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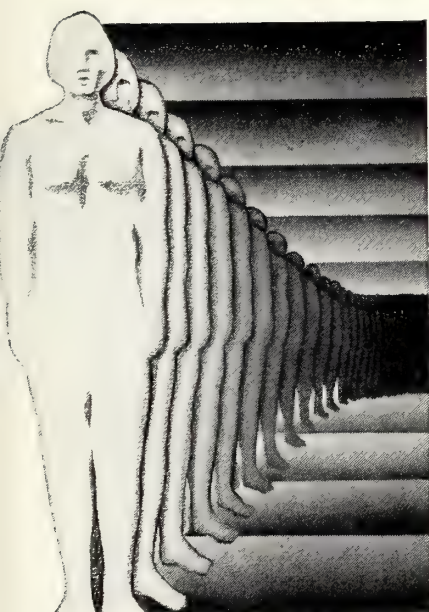
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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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LIBRIUM®

chlordiazepoxide HCl/Roche
5 mg, 10 mg, 25 mg capsules

**IN PAINFUL
ACUTE
CYSTITIS***

*nonobstructed;
due to susceptible
organisms



RELIEVE THE PAIN WHILE YOU ELIMINATE THE PATHOGENS.

FOR THE PAIN

- ☐ **Early relief of painful symptoms** such as burning and pain associated with urgency and frequency.

FOR THE PATHOGENS

- ☐ **Effective control of susceptible pathogens** such as *E. coli*, *Klebsiella-Aerobacter*, *Staph. au-*

reus, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*.

Appropriate antibacterial therapy: Up to 3 days therapy with Azo Gantrisin 4 to 6 tablets *Stat.*, then 2 tablets *q.i.d.*; then 11 days with Gantrisin (sulfisoxazole) may be considered.

AZO GANTRISIN®

(50 mg phenazopyridine HCl and 0.5 Gm sulfisoxazole)

Before prescribing, please consult complete product information, a summary of which follows.

Indications: In adults, urinary tract infections complicated by pain (primarily cystitis, pyelitis and pyelonephritis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Important Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media for patients already taking sulfonamides. Increasing frequency of resistant organisms currently is a limitation of the usefulness of antibacterial agents including the sulfonamides. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 12 to 15 mg/100 ml is considered optimal for serious infections; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period. Contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with gastrointestinal disturbances, because of phenazopyridine HCl component.

Warnings: Safe use in pregnancy has not been established. Teratogenicity potential has not been thoroughly investigated. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis. *C.N.S. reactions:* Headache, periph-

eral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, polyarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Usual adult dosage for acute, painful phase of urinary tract infections is 4 to 6 tablets initially, then 2 tablets four times daily for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment of the infection with Gantrisin (sulfisoxazole) may be considered.

Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine soon after ingestion.

How Supplied: Tablets, each containing 0.5 Gm sulfisoxazole and 50 mg phenazopyridine HCl —bottles of 100 and 500.

ROCHE

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Nutley, New Jersey 07110

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